October 1957

HARVARD MEDICAL
ALUMNI BULLETIN

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*Miller, J.B., et al.: Ann. Allergy, 12:611, Sept.-Oct., 1954.

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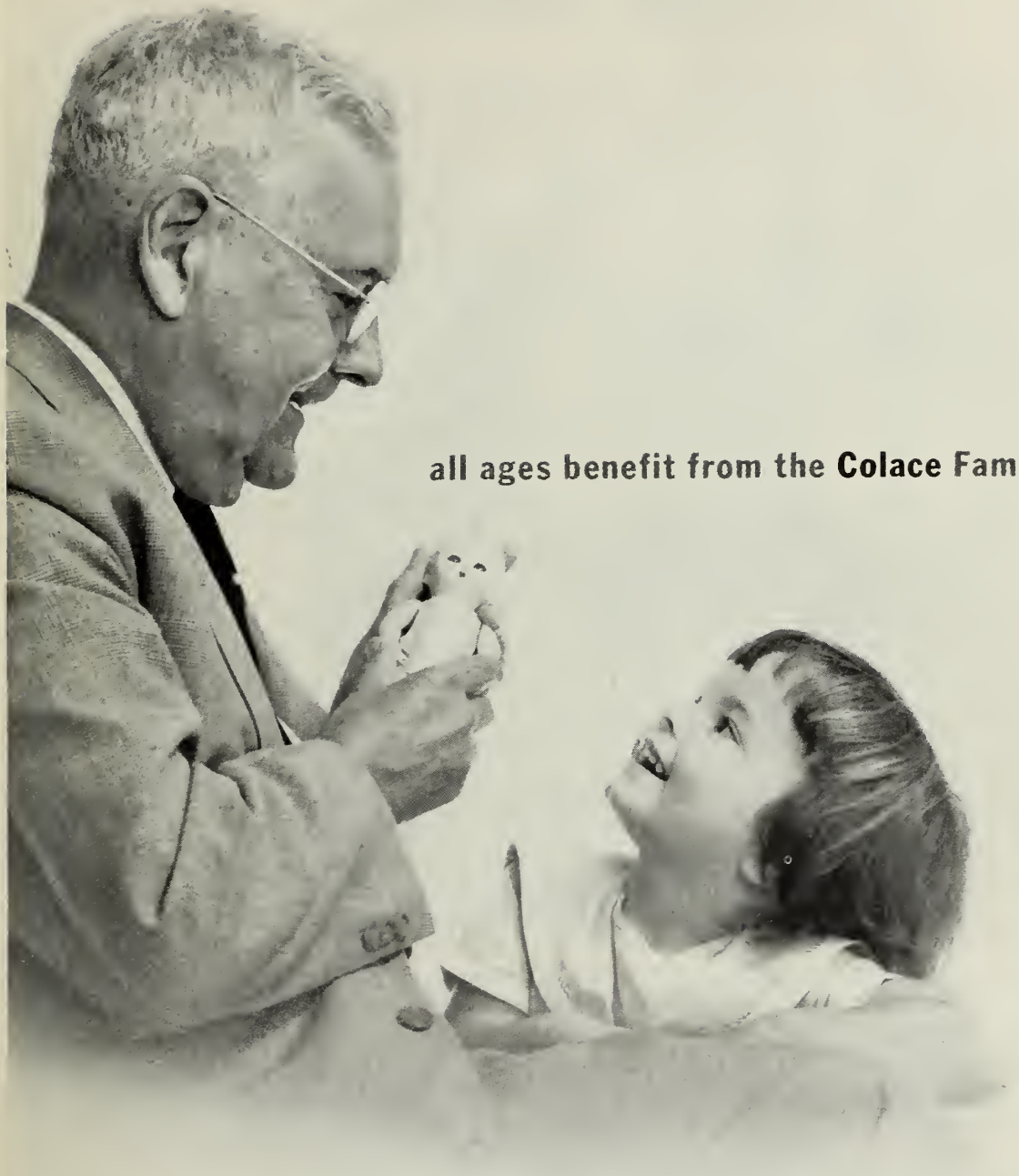

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DIAGNOSIS DEFERRED

"Thar She Blows and Sparm at That"

A clipping from the March 8, 1957, *Vineyard Gazette* of Edgartown, Martha's Vineyard, an island lying off Massachusetts Bay Colony and politically attached to it, proclaims the discovery, in Jack Donnelly's harness room, of Dr. Daniel Fisher's medical diploma. Despite the fact of its being a Harvard diploma, however, dated February 24, 1842, and signed by Johan C. Warren, Johannes Gorham and Jacob Bigelow, its acquirement seems to have been only an incident in Daniel Fisher's life. For it appears that Dr. Fisher, having been admitted to "Gradum in Medicina Doctoris" subsequent to submitting a dissertation on the subject of *Cephalitode Ebriosa,* found that his heart was not in the doctoring business at all.

After a brief essay at making the sick well he apparently found more profit in making the wicks sell, for he is credited with owning at Edgartown the largest sperm candle factory in the world. In addition to this thriving industry he owned an up-Island flour mill, the product of which was brought down to Edgartown and exported by the schoonerload. An unrepentant capitalist, he was first president of the Martha's Vineyard National Bank and owned the first bathtub on the Island, installed with the necessary ancillary plumbing in his house next to the Methodist Church. Later on, according to the same source of information, he was rated in New Bedford's *Who's Who* as worth $100,000, with the brief comment: "Started poor. Formerly physician. Since, an oil manufacturer. A go-ahead, businesslike man, great perseverance and fair benevolence. Once a candiate for Congress."

So much for one of Harvard Medical School's early field-faring physicians.

On the whole the graduates of Harvard Medical School seem to have stuck to their lasts. Among the "doctors afield" that have found their way under this title into the pages of the *New England Journal of Medicine* during the past five years, relatively few have been men of Harvard. General Joseph Warren was a graduate of the College but antedated the Medical School. General Leonard Wood, a graduate, was expelled from his internship at Boston City Hospital for disciplinary reasons, with the bitter comment by the then superintendent that, "There goes a young man who will never come to any good."

Homer Gage, of Worcester, an eminent surgeon of that midwestern (Massachusetts) city and a prominent fellow of the Massachusetts Medical Society, abandoned the scalpel to become president of the Crompton-Knowles loom manufactury. Dr. Samuel G. Howe, an Alumnus of our institution, fought with the Greeks, like Lord Byron, when they gained their independence from the Turks, and was later instrumental in establishing the Perkins Institution for the Blind. Ernest Gruening, a member of the Class of 1911, left school in his fourth year to work for the *Boston American;* from this journalistic springboard he went on to become editor of the *Nation* and eventually governor of Alaska. Oliver Wendell Holmes always kept a spoon in the medical pot through his professorship of anatomy and an active membership in the Massachusetts Medical Society, while he went on to different, more spectacular things; and there have been others, like Robert Montraville Green who remained a surgeon and anatomist even as he pursued his scholarly pursuits.

Most of the doctors afield seem to have been graduates of other schools, if any; literature is the field into which they have wandered most frequently, to cite only such examples as Dr. Rabelais, Dr. Goldsmith, Dr. Schiller, Dr. Chekhov, et al. St. Luke, although a nongraduate, was greatly beloved. Dr. Livingston (I presume) was but one of the explorers; in a similar category were Elisha Kane, who made two arduous trips to the Arctic despite severe rheumatic heart disease, the younger Charcot and Frederick A. Cook, a bonafide explorer before he faked the ascent of Mt. McKinley.

Copernicus was a doctor who hitched his wagon to a whole galaxy of stars. The Smith Bros., Albert Richard and Arthur W., were travelers, lecturers and entertainers, Arthur acting as manager for his brother, who had been an early conqueror of Mont Blanc and thereafter burned to tell the world about it. Usher Parsons, Oliver Wendell Holmes' brother-in-law, had been apprenticed to John Warren—the equivalent to a Harvard degree at that time. Perry's surgeon at the Battle of Lake Erie, Parsons was also a genealogist and biographer and, living in Providence, had seats at the First Baptist as well as St. Stephen's and Central Congregational churches; he joined the Episcopalians at St. John's but was especially fond of the Unitarian service.

Joseph Ignace Guillotin, a moderate revolutionist when he popularized the sharp-tongued "maiden," in whose embrace so many of the aristocracy lost their heads, later founded the French Academy of Medicine; the inventor of the first machine gun was Dr. Richard J. Gatling. Others, like Dr. John S. Ormsby, have been private minters of gold, but Dr. Fisher seems to have been the only one who turned sperm oil into currency.

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Alan Gregg

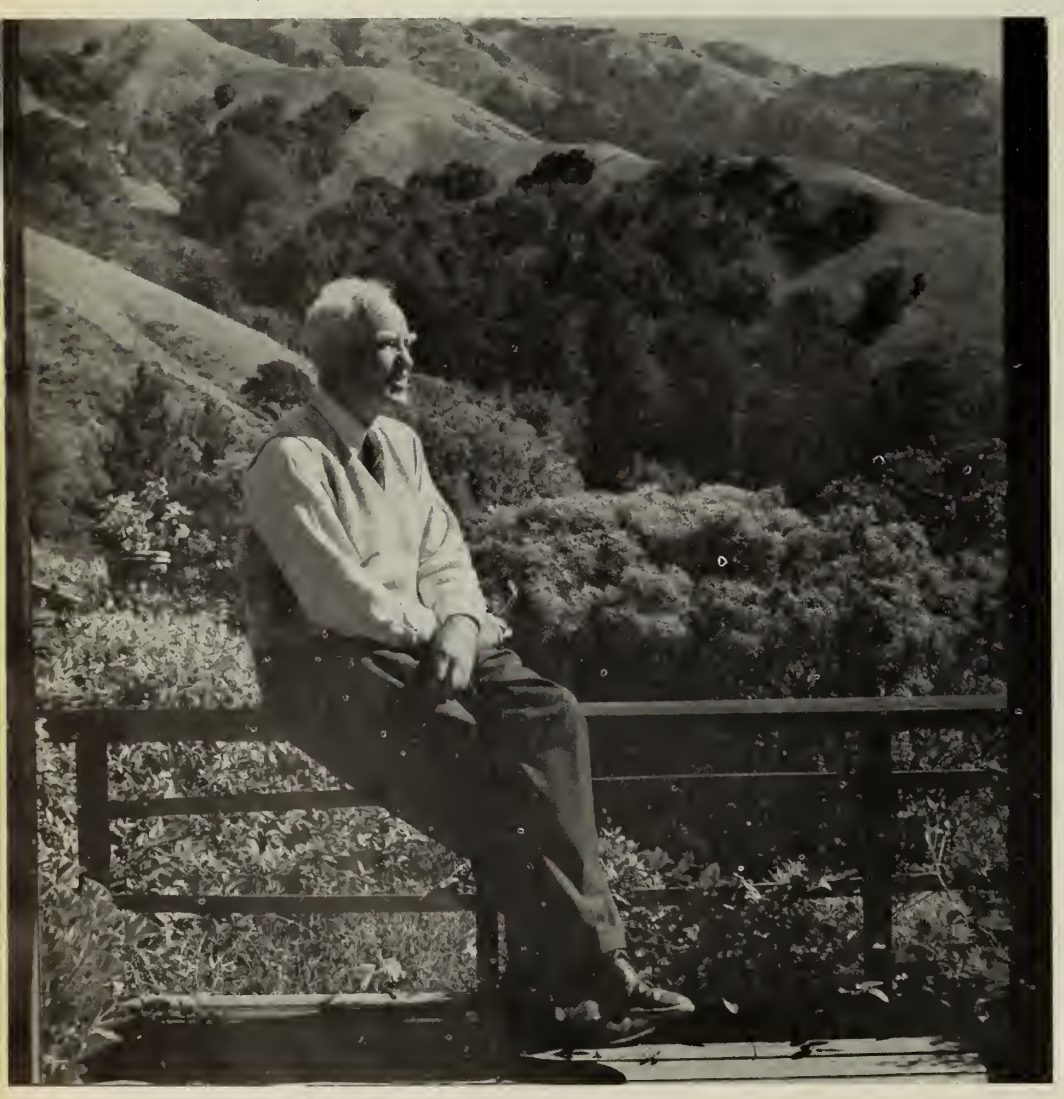
1890-1957

Graduation picture taken in 1916 on the steps of Building A.

In a journal such as ours, there is no need to recount the high achievements of Alan Gregg, Harvard Medical School, 1916. His honors were many, his contributions to medicine were great, and we believe history will record him as one of the outstanding men of our generation in the field of medicine.

It is fitting to record here some more intimate impressions of a truly great physician. In retrospect, one appreciates that even as an undergraduate and intern, his medical thinking was far ahead of his generation. But first of all we remember his kindliness, his integrity and his delightful sense of humor. A sense of humor is basically a sense of values, and Alan's humor and his often-expressed thoughts about the future of medicine showed this keen sense of values. During his intern days, Alan often surprised and intrigued us at the supper table or in the house officers' flat, by his observations on his work on the wards or the outpatient clinic. He saw far beyond the "poor old crock" who had just came into the emergency ward with advanced pulmonary tuberculosis. Alan gave his all of comfort, encouragement and advice to such patients, but he gave far more thought than most of us to questions of why these things should be and what could be done to prevent such human wastage. His subsequent career in the fields of preventive medicine and in medical education of communities and, indeed, of nations has proved the soundness of his early thinking and the fortitude and persistence with which he carried out his ideals.

Dr. Gregg at his home in Big Sur, California, just after retiring last year as vice-president of the Rockefeller Foundation.



His advanced thinking in school and in internship, however, was never the sort that antagonized his associates, for he was never the pedant, or the crusader in the usual sense. It seems tragic that he had such a brief time to enjoy his retirement at Big Sur, California. He had earned this leisure; and knowing Alan as we do, we feel that medicine has lost much in being deprived of his rich store of experience in medical matters and the ideas which he would have so ably expressed.

T. H. L.

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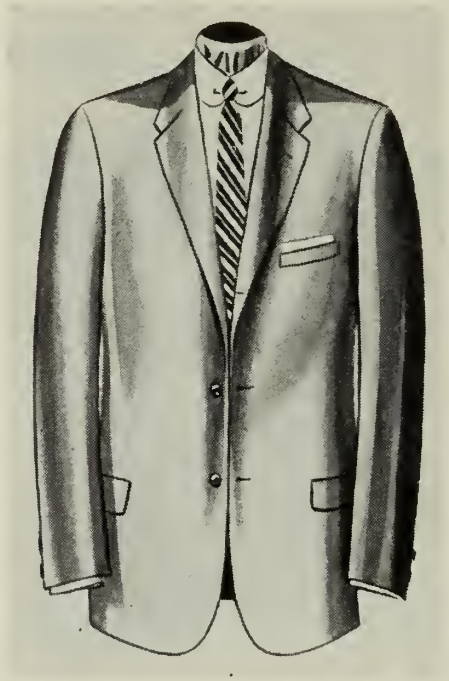

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HARVARD MEDICAL ALUMNI BULLETIN

VOL. 32 OCTOBER 1957 NO. 1

The Cover: *shows the various buildings occupied by our school since its founding in 1782: upper right, Harvard Hall (1782); upper left, Holden Chapel (1783); center, Mason Street (1816); lower left, North Grove Street (1847); lower right, Boylston Street (1883). Holden Chapel and Harvard Hall are still standing in the College Yard in Cambridge. The other three show the succession of buildings used in Boston when it became obvious that clinical facilities for teaching in Cambridge were inadequate.*

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Meeting a Challenge:

The Correlation of Medical Research and Medical Education

Robert H. Hamlin, M.D.

America is proud of its medical institutions, its medical educators, its medical practitioners, and its researchers. This pride is justified. More Americans than ever before recognize, understand, and appreciate the dedicated efforts of our medical schools to make known the unknown.

We have enjoyed significant success in our intense and ever expanding effort to reduce the unknown. We are continually and successfully finding new methods to apply in practice our new knowledge for the benefit of mankind.

Inherent in our successes, however, we must recognize the need in our medical schools for a balanced relationship between medical education and medical research. It is my attempted purpose to analyze the present weighting of this delicate balance.

Two major problems now confront our medical schools. First is the orientation of medical education to meet new concepts and future demands. Second is the need for increased financial support to meet the enormous growth in medical school expenditures.

Basic to an understanding of these two problems is a recognition of the impact on our medical schools of rapidly expanding research programs. We tend to glory in the accomplishments of our research; we subjugate our recognition of—or fail to recognize—the serious complexities to medical education presented by our magnificent research effort.

It may seem strange to say that research creates complexities, for the purpose of research is to simplify, to make more understandable our existence. Succinct analysis will demonstrate, I believe, the considerable effect which research activities have on medical education and medical school financing.

Simplified, the present trends in medical education in our medical schools are four. The first trend: to co-ordinate the basic sciences—particularly anatomy, physiology, and biochemistry—to permit a unitary consideration of human biology.

The second trend: to co-ordinate the clinical divisions to forestall the development of fractionalized teaching through a multiplicity of departments; such divisioned or unmeshed teaching could result from the natural pressures of our ever-increasing specialization.

The third trend: to integrate the basic sciences and clinical disciplines to permit an extension of work in the basic sciences beyond the traditional first two years and an introduction of work in the clinical disciplines in the first two years.

The fourth—and last—trend: to decrease the time devoted by the student to required courses and thereby to increase his time for elective studies so that we may stimulate to the fullest degree the creative, probative forces of the student mind.

Undoubtedly these trends in medical education have been stimulated, directed, and—to a certain extent—misdirected by the rapid growth of research in our medical schools. In research activities we have recognized the need to bring together—either formally or informally—the previously compartmentalized organization of our medical schools. What is good and necessary for medical research may be good and necessary for medical education!

We may be thankful that this lesson in simplification, learned in research, is being applied by our leading medical educators in the reorientation of medical education itself. They have only begun. It is the duty of the clinicians, the researchers, the administrators, and the public to help in weighting this delicate balance between medical education and medical research; between academic freedom and fruitful, cooperative interpersonal and interdepartmental research and teaching.

We are making progress in our reorientation of medical education; the expansion in research activities has contributed greatly to this progress. Nevertheless, expanded research programs in the teaching environment offer obstacles which must constantly be recognized. Examples of these potential obstacles are: First, the sudden availability of research funds may, in itself, stimulate the creation of new departments or administrative groups. This influence conflicts with the accepted objective of closer integration in medical education—integration not only within, but between, the basic sciences and the clinical disciplines.

Second, the pattern of student elective courses may reflect more the research interests and projects of the faculty than an organized attempt to develop the most productive medical curriculum. This problem of effective optional courses will undoubtedly become more acute as student elective time is increased—and this is the trend. Since research

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Editor's Note: This address was given before the Annual Meeting of the Harvard Medical Alumni Association, on May 30, 1957. Dr. Hamlin is Assistant to the Secretary, Department of Health, Education and Welfare.

admittedly affects teaching, then teaching should also be, to a degree, a determinant of research. The latter —teaching as a determinant of research—has become less obvious as the medical schools, under the stimulus of increased research funds, have developed full-time research staffs without teaching responsibilities.

Third, one of the most significant decisions which must be faced by our medical schools is the upper limit upon the total research program conducted by faculty members. The "research center," largely or entirely separate from the medical school, may be the structure within which critically important research on a very large scale may be conducted without disrupting the medical schools and their primary teaching responsibilities.

The fourth, and by far the greatest problem created by the expanded research effort in our medical schools, is financial. Research grants often do not cover full expenses, particularly indirect or "overhead" costs such as building operation and maintenance, library management, insurance and retirement plans, and general administrative services. This deficit in research financing must, of course, be met from the already strained general operating revenue of the medical schools. And, since instruction costs are also paid from the general operating revenue, a reciprocal, potentially detrimental relationship of medical research and medical education must be acknowledged.

The financial pinch in our medical schools is not primarily in research, but in general operating expenses. Concern over deficit financing in research is, therefore, in large part a direct reflection of the general financial insecurity of our schools.

Medical school expenditures are generally subdivided into five general categories: instruction, research, administration, maintenance, and miscellaneous. Total expenditures in all medical schools rose from $31 million in 1940-41 to over $160 million in 1955-56. Significant changes in the pattern of medical school expenditures have occurred in recent years. The most outstanding change has been the sharp increase of over fifteenfold since 1940 in research activities. The proportional share of medical school expenditures for research has more than tripled since 1940, so that almost $55 million, or 35 per cent of total medical school income, is now spent for medical research. The American Medical Association estimates that 95 per cent of this amount is financed by grants from outside organizations; the Federal Government contributes about $21 million, or 60 per cent.

Income from such traditional sources as tuition and endowment has not kept pace with increasing costs of medical schools. The percentage of *total* income received from tuition has been cut in half from about 30 per cent in 1940 to under 15 per cent in 1956. Furthermore, the proportion of income from endowment has fallen from about 18 per cent in 1940 to approximately 6 per cent in 1956, or to nearly a third of its former share.

Private gifts and grants to medical schools have increased. Funds from these sources have grown from about 15 per cent to almost 20 per cent of the schools' income. Physicians themselves in 1956 gave more than $3.3 million to the medical schools; their total includes $1.1 million given by 40,000 doctors through the American Medical Education Foundation, established by the American Medical Association, and $2.2 million given directly to the medical schools by 45,000 doctors.

The decrease in the proportion of income normally provided by tuition and endowment has been offset largely by funds from government. State and local moneys have risen from about 20 per cent in 1940 to 30 per cent in 1956. Federal funds have increased during this period from under 2 per cent to almost 25 per cent, or one quarter, of total medical school income; virtually all of the federal money supports research and the training of individuals.

The overwhelming share of public medical school income has been increasingly derived from government sources, principally state and local. This had increased from 50 per cent in 1940 to 70 per cent by 1951.

Private schools depend principally upon income from private sources, but funds received by private schools from government have increased sharply, mainly due to increased research grants. The share of government income in private schools rose from under 3 per cent in 1941 to over 30 per cent in 1951, while endowment income fell from 27 per cent to 20 per cent. The proportional shares of income from other sources remained relatively unchanged.

The share of expenditures for instruction in public medical schools remained relatively stable between 1941 and 1951, accounting for slightly over one-half of total expenditures. During this same period, private medical schools spent a decreasing share of their total expenditures on instruction as research became a larger and larger element of expenditure. Instructional costs of private schools fell from nearly 60 per cent in 1941 to about 40 per cent in 1951. Research expenditures tripled by comparison, having risen in this period from about 13 per cent to approximately 40 per cent.

Distortions occur when total medical school income is compared to the individual sources of income such as tuition, endowment, and gifts. This is due to the large increases in recent years of research grant funds in total school income. Comparison of traditional income sources with the basic operating budgets of medical schools, which exclude research and training grants from outside sources, will reduce the sharpness of the changing trends—but the relative trends remain.

The complications of changing income patterns are greatly increased in certain medical schools since research funds are highly concentrated among relatively few schools. The present research award system is not well adapted to promote a greater dispersal of research. Thus, acute problems will continue to harass particularly those schools in which

research is concentrated.

Distinct changes in the patterns and pressures of medical school financing have, therefore, taken place during the past fifteen years. Inexorably entwined in these changes have been the great growth of available—and sometimes incomplete—research funds.

The income problems of our medical schools do not arise primarily from an incomplete financing of research. Concern over inadequate financing of research is, again, principally a direct reflection of the general financial insecurity of our medical schools. The Achilles' heel, more specifically, is the lack of sufficient income to meet basic operating expenses, not research costs.

Nevertheless, if research grants do not completely cover all costs of research, these expenses must be met from income which otherwise could be applied to basic operating needs, including instruction. If research grants would recognize and pay all research costs, considerable pressure would be removed, and other responsibilities strengthened.

In varying degrees, both government and private philanthropy have applied the principle that their research grants should not pay full costs. This principle is based upon the philosophy that the medical schools should demonstrate their interest and sincerity by sharing in the expense of research. The practical considerations of limited research funds and a desire to spread the available resources as widely as possible have also had a strong influence in requiring participation.

The Federal Government, which contributes 60 per cent of the research income in our medical schools, does not in many cases pay all expenses, particularly indirect costs. Some Government agencies, to their credit, are now permitted to pay all research grant expenses.

The major share of medical research funds from the Federal Government is granted by the Public Health Service and their National Institutes of Health in the Department of Health, Education, and Welfare. Programs of the National Institutes have been greatly expanded in recent years. During fiscal year 1956, funds available to the Institutes for research, training, and related activities totaled $98.5 million. For the current year, Congress has provided nearly double that amount—$183.2 million.

The 1958 Federal budget requests $190.2 million. This includes $93.7 million for support of research outside the Institutes and $34.5 million for training of research and related personnel. The greater part of the increase of approximately $7 million requested for 1958 would be used more fully to compensate institutions for the indirect costs of research projects supported by N.I.H. grants. Heretofore, a maximum of 15 per cent of a grant has been allowed for such costs. Experience has shown that these costs actually run much higher.

The present Administration and the Department of Health, Education, and Welfare have endorsed the principle of full payment of all costs resulting from their research grants. The consent and approval of Congress are the vital, remaining requisites if this principle is to become practice.

The Federal Government should not, in my opinion, require medical schools to participate in the cost of any research financed by the Federal Government. This conclusion is reached, not on the basis of economic analysis, but upon a recognition of the respective roles of the medical schools and the Federal Government. This is a relationship —a partnership—in which the medical schools perform in their able, unique, and effective fashion the research which Congress has determined should be financed by the Government in the public interest.

As further assistance to the medical schools, the 1958 Federal budget proposes $30 million for grants to nonprofit institutions, medical and dental schools, schools of public health and osteopathy, and related scientific institutions for the construction of health research facilities. This is the same amount appropriated last year for this purpose, for which there is a total Congressional authorization of $90 million over a three-year period.

In addition, the Federal budget again proposes Federal grants to schools of medicine and dentistry for the instruction of teaching and training facilities. The amount proposed for this purpose in the first year is $15 million. Legislation authorizing such aid was proposed by the President last year but was not approved by Congress. The proposal submitted by the President and the Department of Health, Education, and Welfare for Congressional consideration this year requests a 5-year, $225 million combined program for teaching and research facilities. This program has not been enacted.

The efforts of the President and the federal agencies to assist the medical schools are, therefore, extensive. It is hoped that Congress will this year favorably consider and enact those parts of this total program which have been proposed.

The integration—or proper balance between medical education and medical research *is* a challenge to our medical schools. This challenge has existed for many years. It has in the past been met with success. The challenge will continue, but its strength and complexity will undoubtedly increase.

Our ability evenly to mesh the educational and research processes in our medical schools has been further complicated in recent years by several important factors: First, the costs of medical education have hopelessly outrun tuition and endowment income. Second, the schools have accepted with dedication the major responsibility for an enormously increased research effort.

The determination of the most effective balance between medical education and medical research is not a challenge for the medical schools alone. The search for the proper balance is the responsibility of many—the clinicians, the researchers, the medical educators, the government, and the public—all working in a co-operative, productive partnership.

Editorial

THE INDIVISIBLE TRIAD

For every graduate school, there comes a time when the Alumni seek clear-cut information concerning the school's fundamental purpose and direction in the educational scheme of things. Call it honest soul-searching; call it curiosity for comparison of the present with former times; call it what you will. For the student who has attended a fine graduate school and whose livelihood has depended upon the knowledge gained at that school, the desire to understand his Alma Mater better may, with the proper stimulus, reach crusade-like proportions. Such a reaction is certainly more understandable in an alumnus of a graduate school than in one of a college.

At the Harvard Medical School, the activities of the last several years have dispelled any pre-existing lack of enthusiasm—or complacency—concerning the "Old School." Events have taken place on a scale calculated to impress the most unresponsive Alumnus—events that will strengthen medical education and gladden the hearts of the most pessimistic.

It is not trite to state again that the Harvard Medical School believes in the "indivisible triad" of teaching, research, and patient care. There are those who may wonder at the apportioning of emphasis among these three. There are those who are saddened by what to them may appear to be excessive emphasis on research to the detriment of the other components. But it is not always possible under different circumstances to place the same relative emphasis, whether financial or otherwise, on research, on teaching, and on community service. The reason is clear—it stems from the inherent indivisibility of the triad that means excellence. In the simplest of terms, the money spent today to light and heat a research laboratory late into a winter's night may well tomorrow be returned with handsome dividends in the form of new knowledge for the developing student and new methods of therapy for the bedridden patient. Who can measure the values involved?

In recent years the Harvard Medical School has made significant moves to strengthen the indivisible triad: 1) The School's endowment has substantially increased during the past five years. In 1952, the endowment stood at $22,500,000; in 1957 it stands at $34,000,000; 2) The recently incorporated Harvard Medical Center will greatly strengthen the School and its associated teaching hospitals. Through the integrated organization of the School and its Hospitals, the new social and economic stresses which have threatened the stability of patient care, medical education, and research may be met.

Complicated fund-raising programs will be required for the Center to reach its potential. To what use will these new funds be put? The majority of the new resources will be used to strengthen the financial position of the faculty; teachers in the preclinical years; teachers in the clinical years; and teachers in the behavioral sciences. Considered in the broadest terms, increased strength for the Faculty means increased strength for the indivisible triad, for it is the members of the Faculty who act as custodians of patient care, research and teaching. Viewed in another light, benefit from these new funds will also be felt by the associated teaching hospitals.

Despite the apparent dramatic increase in the School's endowment, it is frighteningly apparent that the School is still only able to tread water and that continuing annual increments must be obtained to keep above today's water level.

J. R. B.

MERRILL MOORE

As this issue of the *Harvard Medical Alumni Bulletin* goes to press, word has come of the death of Dr. Merrill Moore.

Dr. Moore was noted for his achievements in the fields of psychiatry and neurology. Those of us on the *Bulletin*, however, will remember him more warmly for his unique contributions to poetry and for his wonderful sonnets that have appeared on these pages.

The Art of Poor Case Presentation

*J. Willis Hurst, M.D.**

Many people are born with the ability to present cases poorly, while others have to work at it. If the curriculum of the medical school can be extended and if a longer period of residency can be obtained, then it may be possible to have sufficient experience to enable every graduate to be able to confuse the listener when presenting even the simplest case. Stated another way—anyone can present a complicated case poorly, but it takes a real expert to "clobber" the case presentation of a simple case.

With this preamble, I shall now attempt to lay down some rules for case presenters that have stood the test of time and are guaranteed to leave everyone confused.

* Professor of Medicine; Chairman of the Department of Medicine; Emory University School of Medicine, Atlanta, Georgia; Teaching and Research Fellow in Medicine, Harvard Medical School, 1948–1949.

"... *the patient has mitral stenosis* ..."

"... *always use notes* ..."

1. Do not refresh you mind prior to the presentation. In fact, if possible, you should avoid seeing the patient before the case is to be presented. If a little information can be obtained from a friend, you will have sufficient information to confuse the listener. Unless the listener is quite astute, he will not be able to detect that you have never really seen the patient. If this is the case, you may be forced to make his interest wilt by giving twelve reasons why you never got around to seeing the patient prior to the presentation.

2. Always use notes. Not only should notes be used, but they should be written on a sheet of paper that appears quite large to the audience. It seems worthwhile to some presenters to create concern by ending up the case presentation by reading around the edges of the note-paper and then searching for some bit of information on the back which never really seems to be found.

3. Always remember that the average listener can only hear for the first five minutes of a case presentation. With considerable practice it is possible for the presenter to cram all the irrelevant material into this period of time, and then go on to the meat of the problem after interest has waned.

4. The end of the presentation is so important that a separate article should be written on it to do it justice, but here are several points worth remembering. (a) Never state why the case is being presented to the group of listeners, since this may bring on an orderly discussion thereby destroying any plan that might have been established for creation of chaos. (b) Some presenters have successfully confused the listener by never asking if there are any questions about the case when the presentation is over, but instead they rush to the conference door and usher in the patient, "sans name," "sans age," "sans drapes," "sans everything." The visiting man is then forced to stumble over the introduction, explain what he is doing there and retake the history and re-do the physical examination. If the presenter is quite agile, he can actually leave the room to make some phone calls under such circumstances. (c) Others have been more successful in causing confusion by asking if there are any questions when the case presentation is over. This approach requires a more seasoned expert than that described in (b). The success of the last approach is directly proportional to how well the unimportant data was selected to present during the first five minutes of the presentation. If this has been successfully accomplished, and if any questions are asked, the presenter can state, "I mentioned this before you came in," or "I guess I lost you for a moment." With just the right inflection and by simultaneously raising the eyebrows, some presenters can imply that the listener was really asleep (which he was).

5. The blackboard can be used very effectively to confuse everyone when the case is presented to a conference. Everyone must use script when writing on the board and must cover up all the space that is available. The material on the board must be written as small as possible. In order to accomplish this, one must not forget actually to test this by sitting in the front row and examining the material. If it can be read in the front row, the material on the board must be erased and rewritten using smaller letters.

Sooner or later the seasoned presenter learns that the best way to confuse an audience at a conference is to place considerable material on the blackboard and then to tell other parts of the story. When this is done members of the audience will do one of three things: (a) Some will try to read the material on the blackboard and listen to the unrelated verbal presentation at the same time. No studies are available regarding flip back," that is, the frequency with which attention jumps from the board to the presenter, but the rate is considerable and is guaranteed to leave the listener confused. (b) Some will read the blackboard and not listen to the presentation. This leaves the presenter in the position of saying, "I discussed that," when a question is asked about material not covered on the board. (c) Some will listen to the presentation and not read the blackboard. The presenter can then simply motion toward the board with a jerk of his thumb when a question is asked about material not covered in the verbal presentation.

"*The material . . . must be written as small as possible.*"

"*. . . always remove the chalk and eraser.*"

Certain additional points could be made here but should really be covered under a separate article entitled, "How to Wreck a Conference." I feel justified in including one point since everyone agrees that poor case presentation overlaps conference wrecking. The point is this—always remove the chalk and eraser when you are through writing a summary of a case on the board. Many teachers use these objects and may find them unless the case presenter goes to the conference room with the prime purpose of removing them.

6. Complicated teaching aids of all sorts can be used to make for first-class confusion; but, if these are not available, the ordinary X-ray view box can be used to accomplish the job. Indeed, this is probably more subtle than, and certainly not as expensive as, many of the elaborate teaching aids. The X-ray view box must be turned on long before the films are to be shown. In fact, it is worth observing an audience when a light, such as an X-ray view box, is turned on. The heads will turn en masse toward the view box to see what is to be seen. The trick is to place nothing there to be seen. The trick is to turn the view box off and wait until you get the attention of the audience again and then repeat the process. It is also useful to show a routine X-ray of the chest but to discuss in great detail the problem that was encountered when you

tried to get the badly needed G. I. series from the X-ray technician. With practice one can learn to take longer with this phase of the case presentation than the history and the physical.

7. A few general rules should be deeply engrained in the presenter. These rules, I believe, are known by most presenters but will be repeated here for completeness. The presenter must not stand still, for to do so will give too much chance of being heard. He must either speak so slowly that the audience is hypnotized or so rapidly that no one can understand him. Finally, if all else fails, the presenter can fail to shave for a few days, and the audience will either count every bristle or wonder if the poor fellow has gone off his rocker.

8. Whenever possible, multiple presenters should be used. It is very effective to have several members of the staff comment on the case presentation, each varying the story slightly, so that the listeners, unfamiliar with the case, will have no notion of what the patient exhibited. When a series of cases is to be presented, then several presenters are to be used. Three separate presenters can cause more than nine times as much confusion as one presenter, if plans are laid properly. One useful trick is to have one presenter outside the conference room door while another case is being presented. The man outside can keep opening the door to see when he is to go on and should indicate that he cannot leave his patient, who is not acting normally.

9. Simple facilities are needed for an examination. Such equipment, including drapes, must be removed. Some thought regarding the position of the patient is needed. For example, if the patient has mitral stenosis and it is necessary to place him in the left lateral recumbent position in order for the murmur to be heard, then the patient must be brought into the conference room in a wheel chair so that the optimum position cannot be obtained.

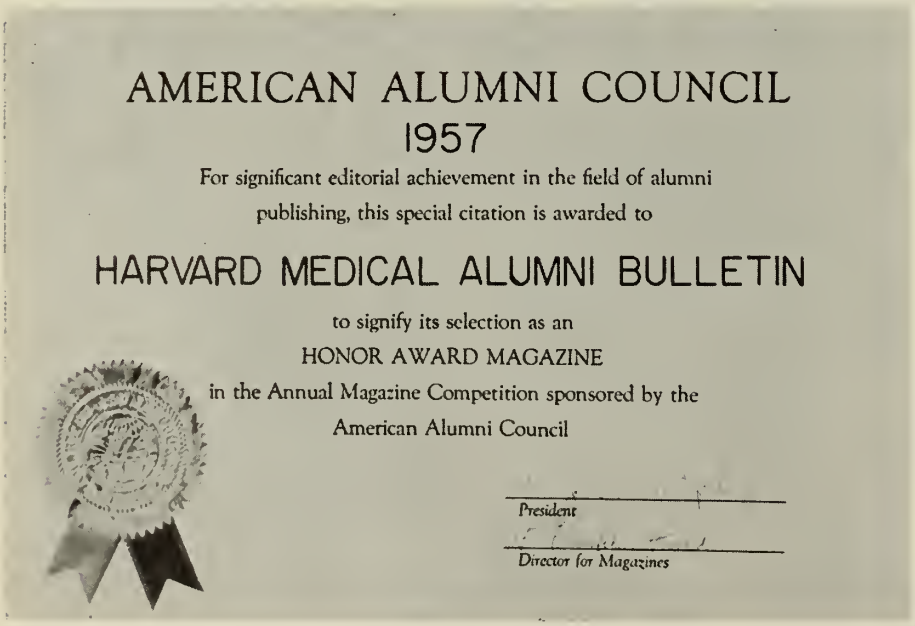
10. Never introduce the patient or thank him for being willing to expose himself to the group of physicians, since part of the plan is to keep everyone guessing; moreover, this failure to show politeness and consideration to the patient will promote a feeling of uneasiness in audience as well as patient. Another clever confusion-ploy in patient handling is to delay the patient's arrival until very near the close of the discussion. And a rule which has often proved ingeniously clever is to fail to see the patient on the morning of presentation, thereby being unaware that vomiting, semi-irrationality or simply loud groaning has begun. Such activities during presentation are guaranteed to shake an audience and make for complete lack of clarity.

Such are the rules. They require a certain artistry, but their charm is that they may be followed as adeptly by the well-trained professor as by the neophyte fresh from medical school. *To disobey the rules: to present a case well; to be considerate of a patient on the "stage;" and to allow one's listeners to grasp a clinical problem clearly—these take time and thought.*

American Alumni Council Awards

The Harvard Medical Alumni Bulletin, edited by Dr. John R. Brooks, shared in four awards in an alumni publications competition at the 42nd General Conference of the American Alumni Council which met at Pasadena, California, June 30-July 4.

The Medical Alumni Bulletin was one of several alumni magazines sharing Honor Awards in the Robert Sibley competition for all-round excellence in the publication of an alumni magazine. Top award in this category was given the University of Chicago Magazine.



In the general awards area (Group I), the Harvard Medical Alumni Bulletin shared in a first place tie (with Roosevelt University) for distinguished achievement in the category of editorial opinion; received a second place in the featured articles section, and was accorded an honorable mention in the section concerning the activities of undergraduates. Group I includes publications representing alumni groups of under 10,000 members.

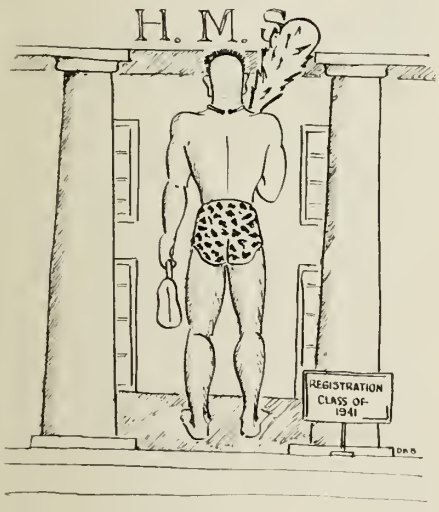
Dr. Brooks is Clinical Associate in Surgery at the Harvard Medical School and Peter Bent Brigham Hospital. Miss Martha Woodbury Dunn served as Assistant to the Editor of the Bulletin. H. S.

Has the Age of Giants Passed?

A Member of the Admissions Committee Attempts to Answer the Frequently-asked Question:

Has the Quality of the Students Admitted to the School Fallen Off?

Curtis Prout, '41



In the past year, the Admissions Committee selected the 114 members of the Class of 1961, our new first-year class. Despite the most earnest efforts of the Committee to consider and weigh every factor in selection, this group is annually accused (and accuses itself sometimes) of looking too favorably on some factors. These include high grades and aptitude tests, one of the sexes, certain colleges, some geographical areas, or certain fields of interest.

Actually, this Committee of 14 has few preconceived ideas, and no fixed rules governing these factors. Each candidate's application is carefully considered, as will be shown. The principal factors considered, not necessarily in the order named, are: intellectual endowment, grades, personal attributes, extracurricular accomplishments, psychological stability, and suitability of motivation.

As time goes by, doctors tend perhaps to forget what their class was like in the beginning. To have projected this group of 20 and 21-year old college students through the shaping forces of medical school, postgraduate training, and the changes brought about by marriage, military service, and practice would have seemed impossible, if one stops to think what he was like when he entered school. Therefore, it might be interesting to look at the Class of '61 in detail, compare it with a class entering 20 years ago, and see whether any changes have occurred and whether any forecasts can be made.

Harvard Medical School has only been graduating women for nine years, so a comparison of 1941 with 1961 is impossible. It might nevertheless be of some interest to attempt to compare other general attitudes and criteria than those which apply to male students. The group used for statistical study covers women students of the Classes of 1949-1954. We have not considered women students graduating after 1954, as they are, for the most part, in the training stage and their careers have not yet been decided.

The number of applicants to Harvard Medical School in the Class of 1961 totalled 1277, with a breakdown of 1187 men and 90 women. Table 1 compares the totals of applicants in the years preceding with the national totals. Notice that, to date, we have not shared in the disturbing drop in the number of applicants.

Of the 1,277 applications for the Class of 1961, all were carefully studied by several members of the Committee; these application forms require sufficient data, including the aptitude test results, college grades, and required recommending letters, so that a good estimate of the student is possible before he is seen.

	Total Number of Applicants	
Class	Harvard	All U. S. Schools
1954	1,113	22,279
1955	1,624	19,920
1956	1,455	16,763
1957	1,330	14,678
1958	1,296	14,538
1959	1,284	14,937

Table 1: Total of applicants to Harvard Medical School and to all U. S. Medical Schools.

Of this group, 484 were further studied and then discussed by the entire Committee. Along with this, further selection was made possible by 1,140 interviews, varying from one to six per candidate depending on the circumstances. Eight hundred and ninty-nine of these interviews were with Committee members; the others with interviewers here and in more distant areas, who have been selected by the Medical School for this purpose. After such an exhaustive screening, it seems reasonable to conclude that mistakes in the admission process could scarcely be blamed on insufficient data or effort. And since a similar process of admissions has existed at Harvard Medical School for twenty years, some comparisons of those selected are possible.

The percentages given in Table 2 are based on a total entering class of 125 students for the Class of 1941, 114 for 1961 (107 men and 7 women), and 35 women admitted to the Classes of 1949 through 1952. It may be seen from Table 2 that the significant changes in the hometown origin of the students in the last twenty years have been that (1) we take less from New England and more from the Northwest and Southwest, roughly paralleling the population change, and that (2) we take many more from Greater New York. And, judging from Table 3, the present Admissions Committee seems to have a bias in favor of country boys (but not country girls) and is bucking the trend away from the farm.

Another question often asked is in regard to our preference in colleges nowadays. This year applicants represented 275 colleges. Of those accepted, the colleges with the largest representation in the Class of '41 were Harvard (35), Yale (9), Stanford (4), California (3), Princeton (2), and Columbia (2). In the Class of '61, the leaders are Harvard (32), Yale (11), Princeton (8), Stanford (3), Columbia (2), Cornell (2). Harvard College had by far the largest number of applicants (175 vs. Yale's 65, Princeton's 54, etc.), so it appears that the selection process hasn't varied in this regard.

A comparison of the aptitude test scores is also of interest. The applicants for the Class of '61 had an average total score of 548 (just above the 50th percentile); the accepted students averaged 620 (about the 88th percentile). In the Class of 1941 the average total score was not comparable, but the percentile level of those accepted was 84; so the aptitude score is no more compelling a factor than it was twenty years ago. It is of interest that four men in the Class of '41 were below the 50th percentile and the lowest entering student (8th percentile) took six years to graduate, the next lowest (22nd percentile) failed in the first year. The other two, with percentiles of 30 and 45, graduated 102nd and 105th out of the class of 138, respectively. The lowest aptitude score in the Class of '61, however, is in the 50th percentile.

The average percentile scores of the women graduates of 1949-1952 was 85. These women's final class standings have been carefully studied by Dr. Harry C. Trimble, and their distribution throughout the class is the same as that of the men.

In the literature sent by the School to applicants for admission it is more than once stated that a broad liberal education is preferred to a narrow scientific preparation. To a certain extent the postwar curricula of most colleges enforce some liberal arts distribution, so virtually no one applies without at least a nodding acquaintance in this field.

In 1941, 80% of the admitted group were science majors, and 20% non-science. In 1961, 69% are science majors, and 31% non-science. Of the women accepted in 1949-1952, the proportion (71% to 29%) was about the same. This, in part, may reflect a trend away from science as a major field for premedical students. We no longer have the data on the applicants for 1941, but for the present first-year class, we selected 9.2% of the total number of non-science major applicants and 8.6% of the science majors: not a significant difference. The college grades of the candidates in the three admitted groups show the most striking statistical differences, however, as can be seen from Table 4.

The factors producing this rise in average grades are many. More high grades are given (and earned) now than formerly, according to many colleges, and it seems that Harvard Medical School has a selected pool of applicants. Since there is not a corresponding rise in the aptitude scores of those accepted, it is reasonable to assume that the students work harder in college than they did, and are being correspondingly rewarded. It is also a reflection

	1941	1961	1949-52 (women)
Urban	48%	47%	44%
Town	27%	30%	28%
Suburban	18%	13%	28%
Rural	2%	7%	—

Table 3: Urban-rural distribution of entering class.

Place of Origin	Percentage Distribution		
	Class of 1941	Class of 1961	Women, '49-'52
Atlantic States	21%	22%	18%
N. Y. City & Suburbs	7%	20%	20%
New England	27%	17%	32%
Midwest	19%	16%	5%
South	11%	8%	3%
Southwest	0.6%	4%	3%
West	7%	4%	14%
Northwest	0.6%	4%	—
Foreign	4%	2%	3%

Table 2: Geographic distribution of entering classes.

	A	B	C	D+
Class of 1941	19 (14%)	75 (56%)	39 (30%)	1
Women, '49-'53	28 (44%)	32 (51%)	3 (6%)	— (including transfers)
Class of 1961	65 (56%)	50 (43%)	1 (1%)	—

Table 4: Average undergraduate college grades of three groups of admitted candidates at Harvard Medical School.

of the strain under which these students are placed. A grade average disproportionately high in relation to the aptitude score might be a warning to the Admissions Committee to look for a college which grades too easily, or a student who is pushing himself too hard.

What happens to the student who has the "A" average? Twenty years after, any effort to correlate this with "success" depends on a definition of this elusive quality and, after carefully considering 1941 in 1957, I prefer to side-step the question. We can, however, compare undergraduate grades with general medical school standing (see Table 5). This table indicates that, in general, high college grades predict higher medical school standing, but that "C" students (as of 1937) were not poor risks. Eight of the top ten graduates in 1941 came in with "A" averages, and the other two came in with "B". Of the 14 who at last count were full-time professors in this class, however, only two came from the premedical "A" group, almost all from the "B" group. Many of these "A" men are now in full-time practice, with no teaching or research affiliations. This could lead to many conclusions as to goals and the factors which determine their direction.

Applying the same criteria to the women graduates of 1949-54, the results are comparable (see Table 6).

Obviously, in judging the less tangible factors of stability, motivation, personal appearance, warmth, and a degree of altruism, no table of statistics can be drawn up. We are trying various tests which may help us to define more clearly some of the personality traits not always described in the recommending letters, but the personal interview remains the keystone of the selection process. This is perhaps as hard on the brain and adrenals of the interviewer as of the student. The interview is not only necessary, but for the interviewer it is a discipline which requires that kind of soul-searching and objectivity that is most rewarding. The interviewer often comes away chastened with new thoughts about what a doctor should be.

Harvard Medical School Class of 1941	Average Undergraduate Grades			
	A	B	C	D+
No. graduating in top ¼ of class	7	23	1	—
No. graduating in second ¼ of class	8	20	5	—
No. failed to graduate in 4 years*		4	1	1
Total number originally admitted	19	75	39	1
*academic failures only				

Table 5: A comparison of undergraduate grades with general class standing at Medical School for the Class of 1941.

The interviewer not only has considerable grist for his own musings about people, he can also refresh his mind on the current interests of today's college seniors. To the non-scientist interviewer, here is a short-cut to current trends in chemistry and physics. In literature, he learns that Kafka is edging Melville and Sartre as the eggheads' favorite. The mention of the word, "existentialism," continues to arouse interest and even excitement in the students, although the definitions elicited seem to have the widest variations.

If one is interested in football, he finds that the present-day variety is too specialized and too time-consuming for the average pre-med, although 1961 has a few of these rugged scholar-athletes, including one who is on somebody's "All-America" team. All in all, there are in various sports 29 Varsity athletes, including 5 captains, in '61. There are also two Olympic figure skaters, one a World Champion. As to music, 17 play musical instruments well,

Women Graduates of 1949-1954	Average Undergraduate Grades			
	A	B	C	D+
No. graduating in first ¼ of class	5	3	—	—
No. graduating in second ¼ of class	9	6	2	—
Failed to graduate in 4 years*	1	1	—	—
Total originally admitted	28	32	3	—
*academic failures only				

Table 6: A comparison of undergraduate grades with general class standing at Harvard Medical School for the women in the Classes of 1949-1954.

and 26 sing in organized groups. Ten have been active on the amateur stage (potential lecturers?) and 16 headed their own fraternities or clubs.

Summer jobs, held by virtually all students, run the gamut of known occupations. As might be expected, the most common are laboratory technician, hospital aide or orderly, and camp counselor, but 1961 can also boast, for example, of the summer cashiers of the Yonkers Ferry and Disneyland. At times, in fact, listening to these remarkable applicants and their stories almost seduces the interviewer into forgetting why he's there.

The interests of the students in the Class of 1961 seem to be neither broader nor deeper than twenty years ago. There is a marked apathy toward politics and in the organized expression of political opinion. At the same time, there seems to be a corresponding increase in those who find the aspect of "service" more appealing than "just making money." In this class there is, to be sure, a spectrum of political opinion, but there are few extremes. Twenty years ago there were at least two outspoken communists in the class, many pacifists and isolationists, and many vociferous upholders of views, both left and right. This was in accord with the spirit of the times. Twenty years later, in 1957, a cross-section of this same class shows a definite shift of opinion to the right, with very few as much interested in the politics which so inflamed them in school. We have here the interesting phenomenon of both the older and the younger classes tending toward conservatism. The tendency of radical youth to pull in its horns when chastened by experience is well known. A question which does arise, however, is what direction the youthful conservatives will take. Will they become more conservative, or may we expect them to turn toward the left in old age?

It was harder to earn a living in 1937, and more of the applicants must have had economic motives uppermost. However, the number of scholarship applications has not dropped off.

Twenty-nine of the Class of 1961 are doctors' sons or daughters and this represents 25% of the Class; the figure twenty years ago was 24%.

If one accepts, then, that we are selecting the same sort of people, is it not possible to predict what will become of the Class of 1961 in twenty years? A questionnaire sent to all of the Class of 1941's surviving graduates, together with its Fifteenth Reunion Report, might furnish some clues. The Class of 1941 is spread out into thirty-four states and two foreign countries; all are, or have been, married, averaging just over three children apiece. Thirty-four are in full-time teaching and/or research, and fifty-three are in full-time practice. The remaining forty-four are mostly combining practice with teaching or research. Several are in Public Health work, and one remained in the Army. All 131 have been actively employed in some phase of medicine for these sixteen years, barring illness, except for one man who took three years off and then resumed practice. He did not state what he did in those three years.

It is not possible at this stage to attempt to project the future of our women graduates in the same manner, because the first of them are only eight years out of school, and their relatively small numbers make statistical comparison hazardous. In the Classes of 1949 through 1953, thirty-five have reported: twenty-five are married, averaging two children each. Three are not in the field of medicine at this time. (One replied that she wished to be active, but being in Japan with her Army husband, she was allowed to do medical work by neither the Army nor the Japanese. She further made the suggestion that we import Japanese housemaids to this country, so that more women doctors could do more full-time medical work.)

A most painstaking study made of women M.D.'s in this country,[1] however, gives us some basis for comparison with our own graduates. It was found that more women than men fail to graduate from medical school, and that one third less are engaged continually in the field of medicine (due principally to pregnancy or disability). Only 57% marry; those who do average 1.8 children. Granting the tentative nature of these findings, a comparison will show that the women graduates of Harvard Medical School are ahead of the national women doctors' average in marriage, childbearing, and utilization of their education. Their activities since graduation, however, conform to the national pattern for women doctors in respect to geographical distribution and division into specialties. Aside from the slightly higher statistics mentioned above, no significant deviations from the national pattern of admissions has shown up. Harvard seems to be following the same general policy on admission as the schools which have graduated women doctors for longer periods.

To summarize, many people apply to Harvard Medical School; about a tenth are admitted, on the basis of a number of criteria whose individual merits are always being argued and reviewed. There seems to be little basis for the cry that today's specimens are inferior to those of 20 years ago; there is even some indication that they are more studious and more solidly conservative than were the graduates of 1941. Those who make the decisions on admissions can profit by their own mistakes and hope to attain increasing objectivity in selection. But whatever standards are applied in a given year, the differences in the final interpretation will probably continue to reflect the forces and spirit of the times and possibly even the beam in the eye of the beholder.

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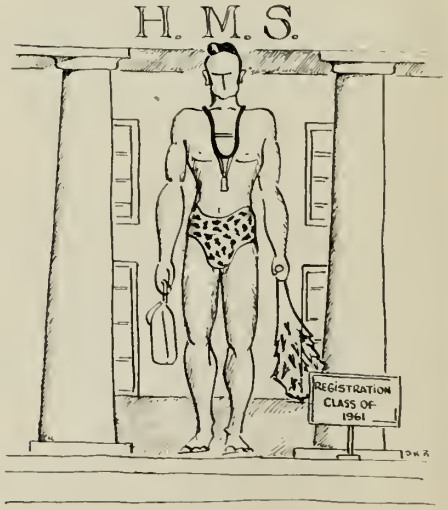


Folie à deux;

or,

I Married a Medical Student

Margen Penick

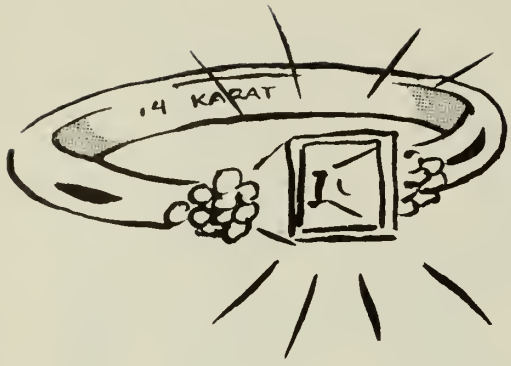
Being married to a medical student is not an easy thing. The medical student is a delicate, high-strung mechanism, which must be pampered, fed, clothed, and soothed at weird hours of the day and night. Sociologists comment dryly on the phenomenon of the married medical student, and how they marry in spite of long hours, short housing, no income, and hard work. I think it is time to look at this development from the opposite point of view: how in the world can medical students find girls who will marry them?

It happens in increasing numbers. Females continue to feel dreamy and heroic about weak-eyed, slump-shouldered medical aspirants, and determine to devote their lives to making his easier.

This is all very well, but in my experience, on 6½ days out of 7, the medical student doesn't notice that his life is being made easier. Wrapt in the mysteries of *Zuckerguslaber*, brooding over the beauties of *lymphogranuloma venereum*, he shovels in his supper, unaware of the hours spent alternating between a hot stove and a cold budget which produced this epicurean delight.

The medical student's mind loses its perspective, for it is bounded on one side by Goodman and Gilman and by Harrison on the other. If I suggest an evening out, Peter thinks of the Library; an "evening in" means having three other medical students over to discuss internships for five hours, having already discussed them every Saturday night since the end of second year; if we invite non-medical friends we lose them, for no business school student enjoys hearing My Day at Mass. General.

Besides losing all your human friends, there are other dangers besetting one on all sides. For example, there is the well-known third year hypochondriasis. I had been going happily along, taking care of the baby and humming in my usual housewifely way when I noticed that an enormous gloom had settled over our little home. Peter looked at me sadly and seriously instead of blankly. He stroked my head and muttered about term insurance. He became more and more noble and self-sacrificing—doing odd jobs about the house, answering his correspondence, and picking up his dirty clothes. He was so saintly and serious that I thought he might ascend at any moment when suddenly he found that he



didn't have Hodgkin's disease after all. All that palpating of himself for nothing. Since he wasn't going to die, he immediately reverted to his normal self. However, I was left in a state of shaken nerves from two months of mysterious gloom and sudden personality shifts.

Another danger to the average medical wife is the literature lying about the house. I was pregnant for the first time, going happily along eating and sleeping and eating and sleeping and eating, when I decided to improve my mind by reading Patten's *Embryology* which had graced our living room table for three months. After I finished the chapter on monsters, and had visions of producing *foetus in foetu* or *amelia*, I was in another state of nerves. Or take the dermatology book. A nice colored picture of *bullous pemphigus* is enough to furnish the laywoman with nightmares for a week.

Worst of all are the other medical students. Somehow they lose their sense of delicacy and appropriateness. Nothing is Sacred. For instance there was the night my husband was elected a member of a medical club. We were sleeping peacefully when a horrible drunken racket started at the end of the street and came closer until it stopped right under our windows. We live in a tiny house on a tiny street in Cambridge, and when you stop under our windows, you also stop under the windows of all our neighbors who include various crabby oldsters of 50, a cop, a stock-broker, and a nervous maiden lady who works at the Fogg Museum. All the neighboring window-shades rolled up with indignant snaps as obscenities and foul language coupled with our name floated on the quiet, three o'clock-in-the-morning air. Peter of course didn't hear it and continued sleeping until I elbowed him into semi-consciousness. I tried to persuade him to go out and make a peace treaty with friends, perhaps giving them some wampum to go away. Peter grunted that we would just pretend to be asleep, and put his pillow over his head.

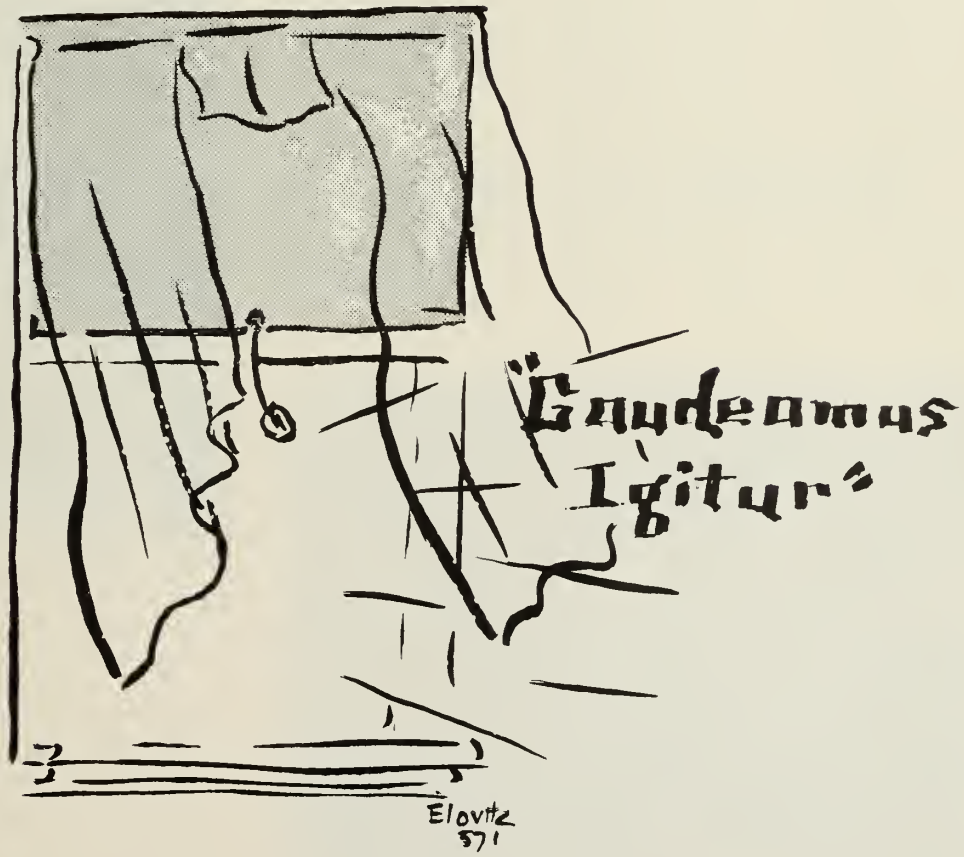
The war party outside was not daunted by our unresponsiveness, and bombed the house with beer cans, lighted a small fire in the street and continued their shouting. Finally they decided to storm the fort. They went crashing about, pounding at walls and windows. Fortunately for the safety of the house, the back door gave way and we had a thundering herd pounding through the downstairs, milling around, opening the refrigerator and generally being jolly. Then they came rushing up the stairs, and pounded on our bedroom door. At this point I had had enough, besides being a little nervous, and forced Peter out from under his pillow. There was a great shout of laughter as Peter slowly opened our door and appeared at the top of the stairs, blinking in the light and looking ineffectual in his costume of underwear and glasses.

When convinced that his colleagues were not leaving

without him, he dressed and went off to drink beer in the Cambridge City Dump and wasn't seen for the rest of the night. If he hadn't gone when he did I know we would have had eight happy clubmen in bed with us, because as I said, nothing is sacred, not even our boudoir.

As you can see, being married to a medical student has lots of drawbacks like losing all your staid, respectable old friends and taking on a shameless group who don't care what they say in front of your mother, and medical students being so psychically delicate: the baby and I creep around the house for weeks before an exam, and Peter goes off pale and green in the morning, and then if he gets one point lower than his best friend I don't dare smile for a week because we are all sharing his sorrow. Not to mention all the things like medical students spending all their time either studying or at the hospital, and smelling like carbolic acid and ether in bed, and learning a gigantic vocabulary of unsociable words, and getting too familiar with the female frame.

It is not an easy job having to study the medical student so you can live with him—the material is inconsistent, unpredictable, irascible, and not really interested in any shadows of his former self, like his wife. As I said before, the sociologists should investigate why it is that so many medical students can find wives at all.



The Back River; Water Color by Howard Ulfelder, '36.

T Wharf; Water Color by J. Gordon Scannell, '40.

Bermuda; Water Color by Somers H. Sturgis, '31.

French Fort, Tenerhir, Morocco; Water Color
by Grantley W. Taylor, '22.

"... he fain would paint a picture..."

Herring River–Low Tide; Water Color by LeRoy D. Vandam, M.D.

Random Notes on the Netherlands

BY A FULBRIGHT SCHOLAR

Alexander S. Nadas, M.D.

In the spring of 1955, as I sat one day in the old dining room of the Children's Hospital, Clem Smith asked me whether I knew of a suitable candidate to go to the Netherlands for a year of work with his old friend, Professor Jonxis. I said that I wasn't sure of a *suitable* candidate, but that *I* certainly was interested in going *myself*.

I had learned to know and respect J. H. P. Jonxis, Professor of Pediatrics at the University of Groningen during his last trip to America, when he was a Lecturer in Pediatrics at the Harvard Medical School, and thought it would be nice to spend a year with him. Also, I had not been back to Europe since before the war, and my wife and children had never been there.

As a result of this luncheon conversation, on August 9, 1956, five Nadases—Johnny 5, Betsy 9, Trudi 11, Elizabeth and Alex, about equidistant from forty on opposite sides—sailed for the Netherlands on the S. S. Ryndam of the Holland-America Line from Hoboken, New Jersey. I was the recipient of a Fulbright lectureship in pediatric cardiology to the University of Groningen for the academic year 1956-1957.

Zadkine's war memorial in Rotterdam

We docked in Rotterdam on August 18 in pouring rain and were met on the pier by K. K. Bossina, the pediatric cardiologist in Jonxis's department. This wonderful young man arose at 4:30 A.M. to meet us in Rotterdam and to escort us back to Groningen. This was the beginning of an unending series of kindnesses that we received from him. These included: 1.) introducing us to "uitsmijters" (ham and eggs, bread and butter, pickles—a wonderful Dutch dish to order in any restaurant at any time of the day or night for hungry people on a limited budget); 2.) getting hold of a child's bed for Johnny instead of the crib (what an insult!) that was in his room on arrival; 3.) negotiating the acquisition of a Giro account (a checking account handled free by the Post Office).

Rotterdam, the largest port in Europe and, I believe, the second largest in the world, is a modern city. It is modern, thanks to the Germans, who in the blitzkrieg of 1940 destroyed it almost completely. The reconstruction is fabulous. There are beautiful new business and residential sections. The railroad station is still under construction. This and the magnificent modern statue of Zadkine's depicting the horrors of war reminded us that World War II had not been forgotten.

Rotterdam is not the only city affected by the war and the German occupation. Most every town still has a bomb crater or a burnt building as a souvenir. Less obvious, but much more poignant, are the mementos in the minds of the people: a sister shot senselessly in the marketplace; an uncle disappearing in a concentration camp; a professor of medicine held as a hostage. Memories of fear, of wooden bicycle tires, of a diet of tulip bulbs will live long in the minds of the Dutch peo-

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Editor's Note: Dr. Nadas is Assistant Clinical Professor of Pediatrics and Cardiologist at the Children's Medical Center. His article describes his year as a Fulbright Scholar in Holland.

ple and will influence their political decisions for some time to come.

A train ride of a little over three hours took us from Rotterdam—near the southern part of the country—to Groningen, the northernmost large city. The railroads are all electric, spotless and fast. Gazing out the window, we were struck by the complete flatness of the land, the black Frisian cattle, the windmills (actually still in use), a man wearing wooden shoes, the canals, and most of all by the Dutch sky. Well known from the paintings of Rembrandt and Ruysdael, this enormous sky, pale blue with the rapidly changing Rorschach of the cloud patterns is an unforgettable part of the Dutch landscape.

Canal in Amsterdam

Thanks to Mrs. Jonxis, a lovely little brick house with large picture windows and a tiny garden in front waited for us in Haren, a prosperous suburb of Groningen. The house was roomy, light, and adequately furnished. Once our books were unpacked, a record player hooked up to the radio and old issues of The *Saturday Review* and *New Yorker* scattered around the house, 17 Botanicuslaan felt almost like home. The kitchen had a gas range and a coal furnace next to it. We brought coal in from the shed in the backyard and once or twice a day returned ashes to the same place. Although this often made us rather homesick for our thermostat in Wellesley, once the fire was going we felt a sense of personal accomplishment. It was also good exercise.

It took me about fifteen minutes every morning to get from Haren to the hospital in Groningen in my little English Ford. The traffic was not as heavy as in the States, but at least ten times as harassing because of its heterogeneity. One must duck innumerable bicycles swooping down from all sides. Horse-drawn carriages, motorcycles, pushcarts, and feeble-minded people (so declared by a sign on the cart) selling brushes complete the confusion.

The Children's Hospital, a long, two-story brick building, is part of the general University Hospital area set in a lovely park. It has about 120 beds and takes care of children up to twelve years of age. I think it is one of the best units of its sort in the Netherlands. Professor Jonxis, a pediatrician of European and world stature, heads it. His interests are predominantly chemical. Important work on amino-acid metabolism and abnormal hemoglobin is done in his laboratory. There is also a good cardiology division under Dr. Bossina, with an active catheterization laboratory; a good angio-cardiographic setup; an excellent surgical association with Professor Eerland; and close contact with the Department of Physiology under Professor Brinkman. Pediatric Cardiology is also closely connected with the group of internists in Professor von Buchem's division. Out of this co-operation grew their excellent record in pulmonary valvotomy under hypothermia and the closure of the first atrial septal defect with the aid of a pump-oxygenator in the Netherlands sometime in April, 1957.

My job was to inject some of our ideas and methods into the cardiology division and to do some small group and bedside teaching in English in general pediatrics to medical students. This was to replace the old germanic classroom lectures still so prevalent on the Continent. Professor Jonxis had been quite impressed by our teaching methods during his visit to the States, and actually introduced bedside teaching for the first time into his Medical School.

The Dutch medical students differ somewhat from their American counterparts. They enter medical school at eighteen or so, having completed the extremely competitive Gymnasium or H.B.S. (high school). The Gymnasium is oriented more toward the classics; the H.B.S. more to science, but both cover much of our college material and, I think, are more rigorous than our high schools.

By the time students enter medical school, they are exhausted from the effort and discipline of the secondary school. In medical school they are confronted by what is called Academic Freedom and a great many classroom lectures in chemistry, physics, anatomy, and physiology. I could never discover exactly what Academic Freedom meant to the Dutch except possibly freedom to take or leave their daily lectures. It certainly did not mean freedom to ask your teacher questions. This was the single most important thing I missed in these young people—questions. The whole system of authority is such that the textbook is accepted as the final word, particularly if reinforced by

The three Nadas children around the statue of the boy (who never was) with his finger in the dike

the grey hair of the professor. The student may not challenge his elders. I need not tell the readers of the *Bulletin* how different this is from our system, but perhaps I should emphasize that it is a barrier that is extremely hard to surmount.

The medical school course takes a minimum of seven years, but some, also within the framework of Academic Freedom, do not finish in ten to twelve years. Students take courses and must pass three sets of large examinations; one for the preclinical, one for the clinical and one for the practical aspects of medicine. If they fail to pass once, they try again and again, so that finally an endurance test between the professor and the student results. How often *can* a student flunk? In the last two years, prior to passing their practical exams, they spend periods ranging from four to twelve weeks in the various clinical departments as "co-assistants" much like our fourth year medical students.

When a student passes all three sets of examinations, he becomes a physician entitled to practice anywhere in the Netherlands—an Arts or a Dokter*. This should be sharply differentiated from a doctor's degree (that is, an M.D. or Ph.D. or D.D.) which is acquired only after presenting or "defending" a thesis of one to two hundred pages before the appropriate faculty. Most of the physicians, thus, are not doctors but Dokters, and only the more ambitious men, aspiring for an academic career, acquire an M.D. degree some years after graduation from Medical School.

The defense of one's thesis—the "Promotie"— is a solemn affair. One works on a thesis for a year or two, has it printed at one's own expense, and dedicates it to one's parents.

Come the examination day, the candidate enters the Senate Room of the University supported on either side by his two best friends, his seconds, the "Paranymphen." The candidate wears tails and so do the two paranymphs. Nervous and perspiring freely, he sits down on one side of a long green table. On the other side are the professors in their academic robes with a copy of his thesis in front of every one of them. The walls of the gilded Senate Room are covered with oil portraits of past professors. Behind the candidate is the audience; in the right corner, his weeping parents and relatives. The Rector Magnificus opens the ceremony and addresses the candidate as "Mijnheer Promovandus," who in his turn answers him and the others who question him, and addresses them as "well respected opponent." They pick apart his thesis in a pleasant but thorough fashion for an hour. At the end, a man in uniform comes in and pounds the floor with a stick three times and says "*hora finita est*." Then they give the candidate a doctorate and he staggers to the reception and has a cosy cup of tea, sherry and cookies with two hundred people. After this, with the two paranymphs, and with a bottle of champagne and an ice bucket, the newly appointed doctor gets into an elaborate horsedrawn "Fiaker" and rides around the town toasting the innocent passersby. Din-

Dr. Nadas (center), with his two Groningen associates

* equivalent to our M.D. degree

ner begins around 9:30 P.M.—a small intimate affair for thirty to forty people in the fraternity house or one of the hotels. The last one I went to, I left at 2:30 A.M. and dessert had not yet been served. As you see, student life is not always dull in the Netherlands.

The University of Groningen is over 300 years old and I think next to Leyden, it is the oldest university in the country. The town has about 150,000 people and is extremely proud of the University. The other pride of the city is the 15th-century St. Martin's Church with a magnificent 323-foot tower. The people of the Province of Groningen pride themselves on their northern sturdiness, silence and dependability. They are people with a distinct character, perhaps like Vermonters or Maine fishermen. It is interesting to contrast them with the "Southerners" of, say, Amsterdam who are considered by the Groningen people as unreasonably temperamental, hot-blooded and not too dependable; all of this presumed character difference exists with less than 100 miles intervening between them!

Amsterdam is a lovely city with a truly cosmopolitan atmosphere and real individuality. I think it fully equals London or Paris in art, music, opera, and, I guess, theater as well. Everybody calls Amsterdam the capital, though The Hague is the seat of government. How this is possible, I could never fathom. The Hague is elegant, Washington-like, but, our Groningen friends say, somewhat stuffy, lacking the urbane sense of humor of Amsterdam. Leyden is delightful; the University has amongst its students Princess Beatrix.

One could go on for pages telling about the towns and villages all over this tiny country of 13,000 square miles. The contrast between the individual flavors, the jealously guarded characteristics of every hamlet in the Netherlands and the sameness and rather national flavor of the entire continental United States is really striking. How long these individual profiles of the small communities can be preserved—and whether they should be preserved—in the face of modern means of communication and transportation is another question.

One final point about the land is the inspiring story of the dikes. The North Sea started to invade the coastline of the Netherlands sometime in the third century and inundated a large portion of it in the thirteenth century. (The Dutch themselves hold no brief for the story of the little boy's finger in the dike, but to lend authority to the legend for imaginative Americans, have erected a statue depicting the alleged scene.) The Dutch started reclaiming the land around 1600 A.D. and have added since that time approximately 800,000 acres (10%) to the country. When the present ambitious plans of draining the Ijselmeer (or Zuider Zee, as it was called before the completion of the enclosure dike in 1932) are completed, another 550,000 acres of new farmland will have been created from the sea. (Incidentally, 170,000 acres actually had been turned into farmland by 1943 and another 135,000 are completely drained now.)

Fascinating and inspiring as the land may be, its 11 million inhabitants are even more wonderful. The whole Nadas family could not have been more "taken" with the Dutch. Their fantastic punctuality (an invitation for 8:30 P.M. is *not* for 8:35), frugality (you turn in every empty fruit jar for ten cents), sense of humor (Jan Steen), and hospitality (they have taken in almost 5000 Hungarians during the recent revolution) deserve real admiration. My wife can't say enough nice things about the erudition of her lady friends, the helpfulness and honesty of the tradespeople that reached her across a considerable language barrier. All three of our children attended Dutch public school, and loved it. The whole medical university community were exceedingly helpful, hospitable and appreciative in their attitude toward me.

When we boarded the S.S. Independence in Naples on June 22, 1957,

Festive windmill

after a lovely three-week automobile trip through Italy (five people and thirteen bags across the Alps in a Ford Anglia), we all felt that this was one of our family's best years. We are profoundly grateful to the Fulbright program for making it possible. We were particularly indebted to Dr. J. J. Van Dullemen, head of the U. S. Educational Foundation in the Netherlands, who, with much understanding and a keen sense of humor, helped us through the few rough spots encountered at the beginning of our stay.

It is impossible to know whether or not we really accomplished our mission. However, I have the distinct impression that we have made a number of good friends in the Netherlands; and that perhaps we have presented to one Dutch community our picture of an American family. I hope we were able to convince our Dutch friends that the U.S.A. is not all rock-and-roll and race riots; and that it is a large country where people of all backgrounds and aspirations live and prosper. Finally, no matter what our momentary differences may be, we all belong to one Western culture to the defense of which we are committed all the way down the line.

The Minot Professorship

On June 5, William Bosworth Castle, '21, became the first physician to hold the George Richards Minot Professorship of Medicine at Harvard. Dr. Castle is Director of the Thorndike Memorial Laboratory and the Second and Fourth Medical Services at Boston City Hospital. He has been Professor of Medicine at Harvard since 1937, and a member of the Faculty of Medicine since 1923.

Dr. Castle's appointment is particularly appropriate since he became Director of the Laboratory and of the Harvard Services in 1948 to succeed Dr. Minot, and since much of his own investigative work has been in the field of pernicious anemia in which he had been closely associated with Dr. Minot.

The directorship of the Thorndike Laboratory has traditionally been held by a Harvard professor and the creation of the Minot Professorship further cements the ties between the Hospital, the Harvard

Medical Unit and Harvard Medical School. This union of medical teaching and research with practice has grown since the Laboratory was opened in 1923, the first clinical research laboratory in the country to be founded within a municipal hospital.

The original grant was donated by George L. Thorndike, in honor of his brother, William H. Thorndike, a surgeon who graduated from Harvard Medical School in 1848. Dr. Francis M. Rackemann, '12, in his biography of George Minot, has underlined the inadequacies of the municipal hospital system and of hospital practice in general as it existed at that time:

"The reasons why the good students of 1921 were not attracted to these large public institutions were not hard to find. Not only was the staff worn down by the enormous routine, but there were neither opportunities nor facilities for making chemical analyses or physical measurements," which might show the worth of new ideas. The stimulation of the questioning student was absent and there could be no improvement in care as long as facilities for thorough diagnosis and care were lacking.

In 1921 Dr. Francis Weld Peabody, '07, became the guiding spirit in the building of the new laboratory. He felt that the laboratory never could and never should become the predominant factor in the practice of medicine, but recognized clearly that in the future sound medicine could no longer be carried on without the support of the laboratory. The dependence of clinic upon laboratory, he realized, would increase rather than decrease.

It is to Francis Peabody, too, that much of the credit for the allocation of additional necessary funds for the building of the Laboratory must go, and it was fortunate that, at his death in 1927, a very capable associate was able to continue his pioneering work. George Richards Minot, '12, was already famous in his own right as co-discover of the cure for pernicious anemia. In the New England Journal of Medicine, Dr. Castle himself wrote a tribute to Dr. Minot in October, 1952: "Although the idea of the relation between good food and good blood has been 'in the air,' . . . many physicians fed diets containing liver to patients without being convinced or at least without convincing others of their value. Only Minot had the instincts and persistence necessary for clear-cut success." The concept of placing suitable facilities for clinical and laboratory investigation close to medical wards populated by patients representing many different disorders has borne rich fruit under Dr. Minot's and Dr. Castle's leadership and has contributed greatly to Harvard's philosophy and strength. Because it was closely associated with the care of patients through its own research ward and through its assistance in the care of Boston City Hospital patients, the Thorndike Memorial Laboratory was able to contribute much to clinical medicine as well as to basic medical research. The relationship fostered notable contributions to the treatment of many diseases, particularly those of the blood. In other fields, under the eye of Dr. Castle, the Thorndike Laboratory has contributed substantially to clinical medicine. Extensive research both at laboratory and clinical levels has been carried out on other aspects of blood disease, on infections and antibiotics; diabetes and nutritional deficiency; on alcoholic cirrhosis and sprue. Dr. Castle received the Walter Reed Medal of The American Society of Tropical Medicine for his work on sprue.

A recounting of Dr. Castle's impressive achievements, however, does not do justice to his human qualities as they are known to those who have worked with him. Although the heavy duties of directing the Harvard Medical Unit have left him little time to conduct research himself, associates say he is happiest when, instead of in a business jacket or long white coat, he has put on a laboratory apron and rolled up his sleeves. Always an advocate of doing things in the simplest way, he takes delight in mechanical repair and keeps a tool box in his office for an emergency case of failing apparatus or equipment, those technical break downs which plague any hospital or research laboratory. Leaky faucets on the wards have known his ministrations late at night. And until recently, Dr. Castle's tall figure, jack-knifed in his Model-A Ford was a familiar sight. The car (known as Castle's extrinsic tractor) was, indeed, almost an institution at City Hospital and at the Medical School, and the reason he gave for keeping it was that he could repair it himself.

Since his youth, he has been an enthusiastic sailor. Dr. Howard Sprague, '22, a classmate of Dr. Castle recalled recently one of the many sea adventures they shared on the New England coast. He told of a stormy September trip from North Haven, Maine, to Gloucester, Massachusetts, in an 18-foot, open motor boat, with one live, crated cat as passenger-cargo. After a rough voyage, which had lasted six days, the motor finally refused further service and forced them to take shelter in Ipswich Bay for a last wet and sleepless night. Next morning, as they limped into Gloucester harbor, they found H.M.S. Calcutta, a British cruiser on a good-will tour, lying at anchor in the harbor. They spied an officer sitting in the stern of the Calcutta, in a wicker chair. Their own open boat flew an American ensign, and with all due ceremony befitting the occasion, Dr. Castle leaned over the stern and dipped the American colors. The officer on the British boat picked up his glasses and, after what must have been some consternation, a hurried blowing of bugles was heard and the British colors were slowly lowered in honor of one small motor boat, one crated cat, and two bedraggled sailors, limping into port.

Dr. Castle braved another storm at the Thorndike Memorial Laboratory. Associates tell of the instance during the 1954 hurricane when the water was flooding down the back stairs of the Laboratory. The drain on the roof was plugged and had to be unplugged before the water could

be stopped. It was Dr. Castle who braved the torrential rivers flooding down the stairs and got onto the roof to unplug the drain.

At the Thorndike, staff members are aware that the spirit under which research is conducted is quite special. They have a deep appreciation of the fact that Dr. Castle stands for the type of research that involves the intimate working together of individuals and is not a research director who substitutes technology for thought. "People who gather around him start producing," an associate has remarked. "He has the imagination that seems to make problems come alive and to take on a new aspect. His constant emphasis on observation of disease in man gives each associate, at whatever level of achievement, a potentially equal role in the process of acquiring understanding of disease and its mechanisms. As administrative duties have taken more and more of his time, this quality of drawing out, inspiring and contributing imaginatively to the researches of others has loomed larger."

The Thorndike Laboratory and the Second and Fourth Services form the teaching unit of Harvard at the City Hospital. Dr. Castle possesses the unique ability to harmonize these Services even when inevitable misunderstandings arise. The Harvard Medical and Neurological Units of the City Hospital have recently been strengthened by the additions of a Harvard Surgical Unit and an Obstetrical Unit. Dr. Castle played a major role in the setting up of these additions to the Harvard family.

In many ways the greatest reward of the efforts of Dr. Castle, his predecessors and his associates at the Thorndike Memorial Laboratory has been to follow the impressive record achieved by those whom they have trained. A large percentage of the Alumni of the Harvard Medical Unit at The Boston City Hospital hold or have held prominent academic positions in medical schools in this country and abroad. Others have made outstanding contributions to clinical research and laboratory investigation.

Although progress itself may come from below, the atmosphere for stimulating and encouraging such progress must come from above. The establishment of the George Richards Minot Chair and the appointment of Dr. Castle as its first incumbent serve as recognition of, and as security for the traditions and leadership that have made the Harvard Medical Unit a dominant force in American Medicine.

Dr. Castle reviews the history of a patient with medical interns and students, during his ward rounds.

Activities of the Dean

With an expenditure of energy that even an Iowa corn-belt farmer might find it difficult to emulate, Dean George P. Berry is devoting his "free" time to the preservation and propagation of what he terms the educational "seed corn" of our nation.

These external plowing and seeding operations in the field of learning at both the university and secondary-school levels—show no sign of abating.

"It is wrong to infer that the Dean has become a spokesman for this or for that improvement in our educational picture," Dr. Berry has recently emphasized in commenting on his role. "It is Harvard—more particularly the Harvard Medical School —that has assumed active leadership."

Though his colleagues and friends in these educational endeavors commonly address him as "George" and refer to him as "George Berry," their more precise term of reference to him embraces his official post as Dean of Harvard's Faculty of Medicine.

"It is not George Berry who is making recommendations for the broadening of educational opportunities for our talented youngsters," the Dean frequently points out. "Rather it is the Medical School and the University. When spoken from the tower of strength that is Harvard, the words of the Dean or of his University colleagues immediately awaken interest and engender respect. The authority stems from Harvard."

During the present year, Harvard will be represented, through Dean Berry, on the newly appointed Consultants on Medical Research and Education to the Honorable Marion B. Folsom, Secretary of the Department of Health, Education and Welfare. Joining nine other experts under the chairmanship of Dr. Stanhope Bayne-Jones, Dr. Berry will study the Department's manifold activities in medical research and education. The Department is currently expending over one hundred million dollars throughout the Nation, and this challenging task presents a tremendous opportunity to set the stage for improving the health of all our people during the decades ahead.

Mr. Folsom summarized his charge to the Consultants in these words:

"Look into the impact of the expanding research program on medical education; the availability of scientists, technicians and facilities; the emphasis given to research in the various disease fields and to the fundamental studies in the basic sciences generally; the relationship between federal and private research programs; the standards for approval of research projects."

Only recently has Dean Berry completed service as a member of The President's Committee on Education Beyond the High School. In non-technical language, the Committee's Report, released on August 11, strongly urged the immediate formation of regional and state committees to explore, in traditional grass-root fashion, all the means that can be mobilized to strengthen and expand the opportunities offered to qualified young men and women to attend college. The very security of our nation demands that society quickly meet this educational challenge.

In the area of medical education, the Dean has accepted service on a small policy committee appointed to advise Dartmouth on the strengthening of its two-year medical school. Hopefully, more doctors can pursue their professional education there.

Harvard, through the Medical Dean, also has a voice—or has had until recently—in the deliberations of such education-centered groups as: The Committee on College Teaching of the American Council on Education; the Advisory Committee on Education of the Veterans' Administration; the Committee on Medical Education of the Massachusetts Medical Society; and the Committee on Educational Research and Services of the Association of American Medical Colleges of which Dr. Berry has been the Chairman for many years.

The annual Teaching Institutes of the Association of American Medical Colleges, which he originally designed and has led for five years, have become the outstanding stimulus in present-day developments in medical education. Its impact is being felt in each of the nation's 82 medical schools and in many medical schools beyond our shores, as well.

The University and Medical School are also active, through the Dean, in organizations that foster medical education and research. These include the Scientific Advisory Committee of the Howard Hughes Medical Institute; the Institutional Grants Policy Advisory Committee of the American Cancer Society; the Josiah Macy, Jr., Foundation; the Commonwealth Fund; and the Louis T. Wright Memorial Fund, Inc. Dr. Berry was also a member of the Medical School Grants Advisory Committee of the Ford Foundation. This Committee formulated the program which led to the Foundation's recent distribution of $90,000,000 to the nation's privately supported medical schools.

Dean Berry serves as a Charter Trustee of Princeton University and as a Trustee of the American University in Beirut.

Finally, Dr. Berry has for years given close attention to ways and means whereby industry may become better informed of the long-range dangers inherent in drawing talented teachers and scientists from the Nation's educational system. Promising students—tomorrow's leaders—cannot all be siphoned off without concern for the future. The disproportionate expenditure of this "seed corn," he has commented, "can lead only to disaster."

BOOK REVIEWS

ROBBINS, STANLEY: Textbook of Pathology With Clinical Applications. W. B. Saunders Company. Philadelphia, Pennsylvania, 1957. 1351 pages.

The appearance of Dr. Robbins' Textbook of Pathology (emanating from the Mallory Institute of Pathology at the Boston City Hospital) is heartily welcomed by those who maintain that a large proportion of our present-day understanding of disease has been contributed by the gross and histological study of diseased organs, and who claim that equally great advances are to be made when gross and microscopic pathology is correlated with submicroscopic structure and function.

The manner of presentation is unique for textbooks of pathology, in that the author has prefaced each chapter with an introductory list of the themes dealt with therein. This is followed by a summary of the normal morphology and function of the tissue or organ under question. Then each disease entity is dealt with, first by discussing somewhat briefly its incidence, etiology, pathogenesis and pathology, first of the acute, and then of the chronic phase. The various viscera involved by each systemic disease are expounded upon at the same time giving a unitarian form of presentation. Discussion is terminated by a correlation of the clinical signs, symptoms and laboratory finding with the pathological alterations. At the end of each section a brief summary deals with the results achieved by modern therapy.

Liberally sprinkled throughout the book are excellent photographs prepared by Leo Goldman.

The chapter devoted to Neoplasia is equivalent in quality to the introductory chapters of the several books which deal solely with tumors, and provides good guidance for beginners and refreshment for those on the road. The same can be said for the chapter on Inflammation and Repair. Here one wishes that the author had expounded further on the role played by ground substance in the healing of wounds.

A section is devoted to Metabolic Disease, in which pathology and biochemistry of disease can be correlated closely. When speaking of glycogen storage disease, the author might have stressed more the recessive Mendelian pattern followed by it, and he might have correlated the abnormal chemical composition of glycogen found in glycogen storage disease associated with hepatic cirrhosis, with the lack of the glycogen de-branching enzyme.

Water metabolism and its distribution are handled succinctly, but several small errors crept into the discussion of edema. Among these is the mention of a critical level of plasma proteins, below which edema formation occurs. Armstrong et al. have found little correlation between the level of plasma albumin, the oncotic pressure exerted by it, and the presence or absence of edema. Further along, mention is made of increased capillary permeability as one of the factors involved in the genesis of cardiac edema, despite the fact that determinations of protein content of edema fluid have consistently failed to corroborate such abnormal permeability. No mention was made of the mechanisms postulated to explain the abnormal retention of salt and water in various disease states. The discussion would have been enriched by the mention of the role played by reductions in effective circulating blood volume and increases in secretion of aldosterone and antidiuretic substances in the production of expansion of the extracellular fluid compartment.

The section on Tuberculosis, often dealt with confusingly in other books, is dealt with in a simple, thorough manner.

Two chapters which will surely catch the reader's eye are those on Collagen Diseases and on Diseases of Infancy and Childhood. The first contains an excellent introduction, and a discussion of exceptional quality of systemic lupus erythematosus. The chapter on Diseases of Infancy and Childhood is quite concise, but lacks a section on retinoblastoma. The reader will miss a chapter on the Organs of Special Senses.

Several of the chapters which deal with systems and organs have been contributed by notable authorities. Dr. G. K. Mallory wrote the section on Diseases of the Liver.

The chapters on the Lymph Nodes and Spleen are commented upon by Dr. F. Parker, Jr.

Dr. J. Foley contributed the section that deals with Neuropathology.

Three years ago Dr. S. B. Wolbach wrote in *The Bulletin* that: "The methods of study (of the science of pathology) should include all disciplines available for studying the reactions of living organisms to injurious agents—morphology, biophysics and biochemistry . . ."

The author's effort to integrate present day pathology with the ever-expanding knowledge of the physiology and biochemistry of disease is evident throughout the text, and it can be said that he has given medical students and post-graduate workers a clear, thorough and nicely systematized summary of pathology as it stands today by itself and in relation to the other basic and clinical sciences.

ELIAS AMADOR, M.D.

WALSH, E. G.: "Physiology of the Nervous System." Longmans, Green and Co., London and New York, 1957. 563 pages.

Dr. Walsh is at present in the Physiology Department of the University of Edinburgh, where his main interests have been clinical research and electroencephalography. His book has helped cross the gap, which has been increasingly apparent, between present-day clinical teaching and practice and the modern concepts of neurophysiology. The new concepts of nerve conduction, the great advances in physiology of hearing and the inner ear and the modern concepts of sensory mechanisms all differ from those which were acceptable 5 to 10 years ago and from what most of us learned in medical school. It is against these new concepts that we must measure this new offering.

The aims of the author, as stated in his preface, are to "place before those interested in clinical neurology an account of the physiology of the nervous system;" to offer "to the psychologist a description in some detail of the physiology of the sense organs and of the cerebral cortex;" to the "advanced student of physiology . . . a summary of neurophysiology in one volume . . . and a guide to the original literature;" to "the medical student . . . a link between preclinical and clinical years."

How far the book goes in meeting the author's aims is difficult to ascertain. Certainly for the medical student and psychologist it is an excellent text. For the neurologist it is interesting reading and a chance to review some of the newer concepts, but he will find some areas of disagreement. For the advanced student of neurophysiology the book probably is adequate as an elementary summary and guide to the classic literature.

The book is comprised of 12 chapters, including 3 sections on nerves, muscles and sensations; 4 on the cortex; 1 each on the auditory and visual systems; and 1 on the cerebellum, labyrinth and posture, and spinal cord. A liberal number of diagrams are included which help illustrate the author's text well. The bibliography contains over 1200 carefully selected references, including many articles as late as 1955 and 1956 and most of the more important contributions from previous years.

The chapters on basic neurophysiology are excellent. Their greatest value is the concise description of modern advances in neurophysiological thinking, especially in such fields as sensory mechanisms and the physiology of the ear. When details are lacking there are a very complete and valuable set of references to which the reader

can refer for more complete information. Unfortunately, one of the difficulties with a book such as this is that it is partially outdated in many ways by the time it reaches the reader. One is given a very reasonable picture of neurophysiology through 1954 or 1955, but then the reader would do well to read the literature directly.

The sections on the cortex, and especially the part that deals with movement, are not as clear as the earlier chapters. Conclusions are frequently drawn that at least some neurologists will find difficult to accept in whole. They remain, however, a reasonable appraisal of our state of knowledge at the present time and only serve to point up the areas of disagreement between various schools of thought.

Dr. John Marshall has contributed a chapter on sensation and one on the physiology of pain. He is an authority on these topics and these chapters are excellent.

This reviewer, who is "interested in clinical neurology" found the text interesting and profitable reading. It is certainly a book that belongs on the active reference list.

I think we can be grateful for the work that Dr. E. G. Walsh has put into this volume and can compliment him on its readability.

H. Richard Tyler, M.D.

NEW APPOINTMENTS

Miss Dorothy Murphy, who for years has held the *ex-officio* title of unofficial "dean" of Harvard Medical School, recently assumed her new duties in the Alumni Office. Dr. Lanman and the members of the Alumni Council have successfully persuaded Miss Murphy to accept the challenging position of Executive Secretary of the Harvard Medical Alumni Association. Owing to her unique knowledge of the School and its graduates, there is no one better fitted to help the Director of Alumni Relations with his many activities on behalf of the School. Much as we shall miss Miss Murphy's skill in dealing with student affairs in the Dean's office, we shall all benefit tremendously from her important new activities.

Perhaps the best account of the esteem in which Miss Murphy is held by the Medical Faculty, students and Alumni of Harvard Medical School was written in the mid-1940's in *Profiles,* published by the Beta Chapter of Nu Sigma Nu. In Volume I of this booklet of biographical sketches from Harvard Medical School, under the title, "Dorothy Murphy," were these lines: "Although not a Faculty member, Dorothy Murphy is certainly an important friend and counselor of Harvard Medical students. Through the maze of endlessly changing courses and thousands of student problems, she efficiently and fairly steers her course, attempting always to keep her family of faculty and students happy and in the right place at the right time."

Miss Murphy

Miss Murphy succeeds Mr. Barrett Wendell who now serves as Executive Assistant to Dr. Ross McFarland in the Harvard-Guggenheim Center for Aviation Health in the School of Public Health.

* * *

Dr. Davis

Dr. Bernard D. Davis, '40, has been named to succeed the late Dr. J. Howard Mueller as Professor of Bacteriology and Immunology and Chairman of the Department. Dr. Davis since 1954 has been Professor of Pharmacology and Chairman of that Department at the New York University College of Medicine.

A physical chemist and physician who has become a bacteriologist and pharmacologist, Dr. Davis has recently devoted his research efforts to studies of bacterial mutants.

Since 1942 and prior to his New York University appointment, Dr. Davis was associated with the U.S. Public Health Service.

As Head of the Department—the first Department of Bacteriology and Immunology to be established in the United States for the instruction of medical students and one of the first organized in the world—Dr. Davis follows Dr. Mueller, Dr. Hans Zinsser and Dr. Harold Clarence Ernst. Dr. Ernst, in 1885, gave the first series of lectures in bacteriology at Harvard Medical School.

RETIREMENTS

Four clinical professors in the Faculty of Medicine of Harvard University retired on June 30, 1957, to become clinical professors, *emeriti*. Altogether, these four men have contributed more than 160 years of service to the practice of their various specialities of medicine and to the instruction of successive classes of students in the Harvard Medical School. They are: Dr. Thomas R. Goethals, '16, Clinical Professor of Obstetrics; Dr. Chester M. Jones, '19, Clinical Professor of Medicine; Dr. Thomas H. Lanman, '16, Clinical Professor of Surgery; Dr. Samuel A. Levine, '14, Clinical Professor of Medicine.

Dr. Thomas R. Goethals, Clinical Professor of Obstetrics, was born on December 14, 1890. He attended Harvard as an undergraduate and Harvard Medical School thereafter, receiving his M.D. degree, *magna cum laude*, in 1916.

On the staff of Harvard Medical School for 37 years and Clinical Professor of Obstetrics since 1930, Dr. Goethals is a recognized authority on obstetrical problems concerned with breech births. He served as Senior Obstetrician at the Massachusetts General Hospital from 1930 to 1950 and is currently a member of the Board of Consultation of that hospital. Since 1946, he has been Senior Obstetrician at the Boston Lying-In Hospital.

The son of General G. W. Goethals, the engineer responsible for the building of the Panama Canal, Dr. Goethals himself served the armed forces in two world wars, rising in the Army Medical Corps from the rank of lieutenant to that of brigadier general. During World War II, he served in North Africa and the European Theater of Operations. His last post with the Medical Corps was as Commanding Officer of Lovell General Hospital in Ayer, Massachusetts. Between the two wars, Dr. Goethals' "principal avocation" was to maintain interest in the Army Medical Service Reserve.

For his distinguished service, Dr. Goethals has been elected to fellowship in numerous medical and obstetrical associations. He is a Fellow of the American Association of Obstetricians and Gynecologists, a Diplomate of the American Board of Obstetrics and Gynecology and a member of the medical scholastic honorary society of Alpha Omega Alpha. While he is doing less in the way of active private practice, Dr. Goethals continues to take a great interest in affairs of the Lying-In Hospital, the Medical School, and the Alumni Association.

* * *

Dr. Chester M. Jones is a nationally known authority in the field of internal medicine with special emphasis on diseases of the stomach and intestinal tract.

Dr. Jones was born in Portland, Maine, on March 29, 1891. His undergraduate years were spent at Williams College, and he received the M.D. degree from Harvard Medical School in 1919. For three years, he worked with Nobel Prize winner, Dr. George Minot, '12, an experience he has described as "priceless." In 1924, he spent a year of study in Strasbourg as Moseley Traveling Fellow.

Dr. Jones joined the Harvard Medical School Faculty in 1921 and has been Clinical Professor of Medicine since 1940. For 26 years, Dr. Jones was Physician at Massachusetts General Hospital, where he was responsible for the revision of the Postgraduate Course in Internal Medicine. For the past three years, he has been Consulting Visiting Physician and is now a member of the Massachusetts General Hospital Board of Consultation.

As Consultant in Medicine to the Surgeon General of the United States from 1944-48, Dr. Jones acted as vice-chairman of a medical mission to Austria in 1947 and to Greece and Italy in 1948. He is a member of numerous medical societies and was elected chairman of the American Board of Internal Medicine for 1955-57. In 1956, Dr. Jones was chosen Shattuck Lecturer by the Massachusetts Medical Society. He continues his active interest in the Hospital and medicine and is also a member of the Editorial Board of the New England Journal of Medicine.

* * *

Dr. Thomas H. Lanman has been actively engaged in the teaching of surgery at Harvard Medical School since 1920. He was a pioneer in the surgical treatment of pulmonary disorders of infants and young children and, at the Children's Hospital, developed methods of dealing with urological disorders of infancy and childhood which have become standard procedures throughout the world. In 1954 he became the first recipient of the William E. Ladd Medal of the American Pediatric Society for major contributions to pediatric surgery.

Dr. Lanman served in the Army Medical Corps during World War I and in World War II. He went overseas in 1942 as Chief of the Surgical Service of the Fifth General Hospital and held various positions in the European Theater of Operations. At the end of the war he was Surgical Consultant to the Twelfth Hospital Center, with the rank of Colonel.

Currently, Dr. Lanman is Consultant in Surgery at the Peter Bent Brigham Hospital and Visiting Surgeon at the Children's Hospital. The New England Surgical Society elected Dr. Lanman its president for 1947-48, and he was in the same year President of the Boston Surgical Society. A member of the American Surgical Society and the Massachusetts Medical Society, he was president of the latter organization in 1952-1953. From 1953 to 1955, Dr.

Lanman served as chairman of the American Board of Surgery.

As Director of the Harvard Medical Alumni Association, Dr. Lanman has in recent years increased manyfold the resources of money and Alumni support available to the Medical School. In this post, he continues his active interest in the Medical School as well as in the *New England Journal of Medicine* of which he is an editor.

* * *

Dr. Samuel A. Levine enjoys wide recognition as a specialist in heart disease. He was among the first to diagnose and describe coronary thrombosis, and one of the early users of the electrocardiograph for the study of cardiac action in patients.

Born in Lomza, Poland, on January 1, 1891, Dr. Levine's parents emigrated to the United States when he was three. He was the second newsboy to receive a Harvard scholarship established by the Newsboys' Union of Boston. He received his A.B. from Harvard in 1911 and his M.D. in 1914. Dr. Levine joined the Faculty of Harvard Medical School as an Assistant in Medicine in 1919 and was named Clinical Professor of Medicine in 1948. He is presently a member of the staffs of the Peter Bent Brigham, Newton-Wellesley and Beth Israel Hospitals.

Beyond the clinical fields, Dr. Levine has been most successful in the training of young physicians who specialize in heart disease. A pioneer in the use of the electrocardiograph, he nevertheless impressed upon his students the continuing value of the use of the stethoscope and of simple bedside methods in examination of patients.

Dr. Levine has contributed more than 150 articles to the medical literature on heart disease and has won many honors. The late Charles E. Merrill, then senior partner in the New York investment firm of Merrill, Lynch, Pierce, Fenner and Beane, in 1954 established the Samuel A. Levine Professorship of Medicine at Harvard Medical School, honoring his warm personal friend and physician.

Dr. Levine continues to have an active interest in his patients as Consulting Physician in Cardiology at the Peter Bent Brigham Hospital.

Honoring Miss Holt on her retirement are, left to right, Mrs. Walter B. Cannon, Dean George P. Berry, Miss Holt, Dr. C. Sidney Burwell, '19, Chairman of the Library Committee, and Dr. and Mrs. Elliot P. Joslin, '94.

* * *

Miss Anna C. Holt, Librarian of the Harvard Medical School, School of Dental Medicine and School of Public Health since 1935, retired on June 29. She has served the Library of the three Harvard Schools since 1920.

Dr. Sidney Burwell, Samuel A. Levine Professor of Medicine at Harvard and Chairman of the Library Committee of the three schools, called attention to the high regard in which Miss Holt is held among the leading medical librarians in the United States. "She knows more about the history of Harvard Medical School than anyone else," Dr. Burwell added. "The Library has been the repository for all the School's historical material and Miss Holt was the first to classify and organize this material."

During her more than three decades of service, Miss Holt has been of immeasurable assistance to more than 10,000 medical, dental and public health students at Harvard. A graduate of Radcliffe College, she came to the Library in 1920. The Library was then located on the first floor of the Administration Building of the Medical School. It was expanded in 1928 to larger quarters on the second and third floors of the building and includes separate units in the Harvard School of Dental Medicine, and several departmental libraries in both the Medical School and the School of Public Health.

Substantial changes in the basic content of the Library have been made since Miss Holt first became associated with it in 1920. Microfilming is one important innovation of this period and has not only brought about more efficient use of books but has in part answered a critical storage problem.

Another important change during Miss Holt's service to the Library is the shift of emphasis in the Library collection. From what might be termed a general medical library containing medical texts, monographs, medical journals and a few scientific journals related to medicine, the Library has grown to be highly specialized.

Dr. George P. Berry, Dean of the Faculty of Medicine, commenting on Miss Holt's long service, said: "In the hearts and minds of the students and Faculty of the three Schools, Miss Holt has won a warm place for herself. She has contributed immeasurably to the growing intellectual life of the Harvard medical area."

HONORS

Dr. Joseph C. Aub, '14, a member of the Board of Consultation, Massachusetts General Hospital, Professor of Research Medicine, *Emeritus*, Harvard University, and formerly Director of the John Collins Warren Laboratories of the Huntington Memorial Hospital at the Massachusetts General Hospital, was recently elected a Member of the National Academy of Sciences in Washington. This honorary position places him in an advisory capacity to the Government in all phases of science and was given in recognition of Dr. Aub's many achievements in medicine, research and teaching.

* * *

Quod profecit medicina recensuit, quid profectura sit acri acie providet, profectus pars ipse magna est.

These words of praise honored Dr. John F. Fulton, '27, who received the honorary degree of Doctor of Letters at Oxford University, England, on June 26.

Dr. Fulton, Sterling Professor of the History of Medicine at Yale University, was among six considered eminent in their fields who received honorary degrees from the famous ancient university. Chosen from industry, the arts, politics and science, they included such distinguished men as Sir Christopher Hinton, head of the industrial development of the United Kingdom's atomic energy program; Sir Laurence Olivier, famous actor, producer and director; Viscount Waverley, former Chancellor of the Exchequer; Lord Heyworth, head of Unilever, Ltd.; and Sir Roger Makins, former British Ambassador at Washington.

The award ceremonies took place on a bright, sunny day after the procession, led by the Chancellor of the University, Lord Halifax, had gone from Worcester College to the Sheldonian Theater. At the award giving, Dr. Fulton was cited for sympathetic and inspired teaching in the varied researches of pupils drawn from all parts of the world. Combining a career of scientist, teacher, and writer, he has founded two journals; his book, *The Physiology of the Nervous System*, has become a classic. In 1946, his biography of Dr. Harvey Cushing, '95, appeared, and he has authored studies on other leading figures in science and medicine.

Dr. Fulton's pioneer work in neurophysiology during the 1920's and 1930's outlined the basic concepts of the workings of the brain and led to the introduction of the frontal lobotomy operation.

* * *

For outstanding work in the field of nutrition, Dr. Tom Spies, '27, on June 4 was given one of the highest honors that can be awarded to a physician in this country: the Distinguished Service Medal and Citation of the American Medical Association.

Graduated from Harvard Medical School, Dr. Spies' research work in the early 1930's proved that pellagra was not a disease but due to dietary deficiencies. Subsequently, he pioneered in advocating diet supplement by different vitamins at a time when separate food elements were just beginning to be discovered and the beneficial effects of vitamins were as yet unexplored. Of outstanding importance has been his study of the dietary requirements for the preservation of tissue integrity.

Following internships at Peter Bent Brigham and Boston City Hospitals, Dr. Spies interned at Cleveland's Lakeside Hospital. Working with alcoholic pellagra patients, he demonstrated that this "alcoholic pellagra" was not due to alcohol, but to the neglect of proper diet that accompanies alcoholism, and that "alcoholic pellagra" was similar in nature to the "endemic pellagra" that ravaged his own South.

When niacin was discovered to be effective against an animal disease similar to pellagra, Dr. Spies added niacin to pellagra patients' diets, and this proved to be one factor which contributed greatly to improvement. He was also instrumental in demonstrating the beneficial effects of folic acid in the treatment of several types of anemia.

In 1938, Dr. Spies, with R. R. Williams, co-authored a book entitled, *Vitamin B_1 and its Use in Medicine*.

Not confining himself to investigation, Dr. Spies has combined research with teaching since the end of his internship. He has held successive teaching positions at Western Reserve University in Cleveland, the University of Cincinnati College of Medicine (where he combined teaching with the post of director of investigation) and Northwestern University Medical School, where he is currently head of the department of nutrition and metabolism.

About eight months of Dr. Spies' year are spent in Birmingham, Alabama, where he has directed the nutrition clinic of the Hillman Hospital since 1936. Two months are spent in Chicago at Northwestern University and the remaining two months in Havana and San Juan, where he is currently working for the elimination of tropical sprue.

Joining the American Medical Association in paying tribute to his extensive contributions to dietary research, the United States Congress on July 23 passed a Concurrent Resolution: "That the Congress and the American people hereby express their gratitude to Doctor Tom D. Spies for his noteworthy medical achievements toward alleviating the sufferings of his fellow men and for his outstanding contributions to the knowledge of the science of human nutrition, especially in the field of earlier and better methods of diagnosis and treatment of nutritional deficiency diseases."

Thomas Vincent Healey
1917-1957

The death of Thomas V. Healey, '43B, in Worecster, Massachusetts on August 26, 1957 brings sad news to his friends and classmates.

For the past year, complications of the diabetes that began in Medical School overtook him. He developed retinal hemorrhages and then, in the spring, severe renal disease brought him to the hospital and eventually led to his death.

Tom had had a perfectly wonderful career. His record in college was almost unparalleled. He graduated *summa cum laude;* was a member of Phi Beta Kappa; was a member of the Student Council; captained the baseball team, played on the football team; and was 1st Marshall of his Class.

In Medical School, he did equally well, in spite of the shock he must have received on realizing he had diabetes. He graduated high in his Class and then proceeded to acquire a sound training in general and chest surgery at The Boston City Hospital. Since 1949, he had been engaged in surgical practice and teaching at the Worcester City Hospital.

In 1948 he married Anne Sullivan. They had three children.

Tom Healey's short life was well-spent. More than these tangible honors and positions of impressive responsibility that he gained, there were the less easily appreciable aspects of his way of life that were better known to his friends.

He was outstandingly honest and completely straightforward in his dealings with others. He expected the same from his colleagues and was understandably distraught when such was not forthcoming. He had a bright and well-ordered mind that could sort out and store important facts for such a time as they were needed. He was an indefatigable worker with impressive drive and ability.

For many of us in Medical School, his striking character trait was his ability to befriend people and make them comfortable in his presence.

Dr. Healey

Whether one sought serious advice on a personal subject or a medical problem, or whether one sought to be entertained by his mischievous sparkling humor, both could readily be called upon and were liberally shared.

The clear memory of these so-recent Medical School days makes his death seem even more bewildering and difficult to accept.

J. R. B.

Roland Hammond
1875-1957

Roland Hammond, recognized professionally as one of the leading bone specialists in Rhode Island before his retirement, died recently at the age of 81. Dr. Hammond had a long and distinguished career as an orthopedic surgeon. He was a man of wide interests and his sound common sense reflected his New England ancestry.

Born on July 29, 1875, in Bellingham, Massachusetts, the son of Dr. Roland and Mary (Rockwood) Hammond, his boyhood was spent in Brockton where he received his early education before going to Tufts College. There, he received his bachelor's degree in 1898. He graduated from Harvard Medical School in 1902 and following an internship at Rhode Island Hospital began practice in Providence, and remained there until his death.

Dr. Hammond held many important posts and, since 1935, had been consultant in orthopedic surgery at Rhode Island Hospital. He was a consultant at St. Joseph's Hospital and chief of the orthopedic department at Memorial Hospital. During World War I, he was a medical officer in the Navy, serving at Newport and overseas in London and in Ireland. He continued as lieutenant commander in the Navy Medical Corps Reserve, until his retirement in 1938.

He was a member of the American Orthopedic Association and served as its vice-president. A member of the American Academy of Orthopedic Surgeons, he also served on the regional committee on fractures of the American College of Surgeons. He contributed many articles on orthopedic surgery and on the history of medicine to medical journals.

One of the most entertaining of Dr. Hammond's many interests and hobbies was his interest in Sherlock Holmes. He was an ardent collector of items relating to the life and times of Holmes and an enthusiastic member of the *Baker Street Irregulars* of New York and the *Speckled Band* of Boston. Some years ago, he founded the *Dancing Men* of Providence, another Sherlockian organization. In addition to the above, he was much interested in ornithology, gardening, art, music and travel. Mrs. Hammond and he had traveled extensively in this country, Europe, Hawaii and Alaska. He had a full life and contributed much to his patients, his profession, and to his fellow men.

T. H. L.

John Walter Baker
1860-1957

John Walker Baker, '81, died on August 7 at Portsmouth Naval Hospital. It is particularly sad to record the death, at the age of 96, of Dr. Baker because over the years he had shown such a keen interest in the activities of Harvard Medical School. Although unable on account of his lameness to get about easily, he never failed to send kind greetings to the School on Alumni Day. He was an eager reader of *The Bulletin*, and his friendly comments on what was going on in our school in a changing era were always pertinent and flavored with the wisdom of a man old in years but ever young in spirit.

Only a few weeks before his death, he sent to Dean Berry and to Dr. Lanman, Director of Alumni Relations, two beautiful ceremonial swords used by officers in the Japanese Navy. These he had obtained in 1882 when, as a recently graduated Harvard Medical School Alumnus, he was serving as a medical officer in our Navy and was a member of the so-called "Good Will Tour" made by the United States Navy in that year. The swords were obtained in Nagasaki and, as Dr. Baker trenchantly observed, the occasion of the United States Air Force's visit to Nagasaki in 1945 was far different from the Good Will Tour of 1882. Dr. Baker also served as medical officer with Admiral George Dewey at the battle of Manila Bay in the Spanish American War.

In 1956, an item in the *New York Times* recorded that Dr. Baker, at 96, had "foiled the actuaries by outliving his insurance policy," and had collected.

We shall miss him here at the Alumni Office, but think with great pleasure of his last letter in which he made the characteristic remark, "I'm out to break the record of my aunt who lived to be 104."

T. H. L.

George Bernays Wislocki
1892-1956

Today I walked along the Wislocki Beach; we always call it that. It was a fine clear day with a light sou'wester, and the ocean was smooth and dancing in the noon sun. There was no one else on the beach. The rocks were glistening with rockweed and you could see the blue mussel shells peeping through.

George used to gather mussels and chop them up with quahogs and mix them in vichyssoise to make an elegant chowder. He was a bit of a gourmet and he often drove into the back country to the farms and came home with the best strawberries, the best heads of lettuce and the best ears of corn. He had little patience with cellophane-packed and processed food.

This was in keeping with his aristocratic tradition and his cultivated taste in painting and in people. He was proud of his Polish lineage and never was without the impressive seal ring which bore his family crest. But with all this, he was modest and the champion of the oppressed. He hated bigotry and intolerance and had little room in his life for the meretriciousness that sometimes goes with the "best people." I've never known anyone who could see through sham so quickly and who stood more firmly for the best in our democratic tradition. All this is beyond his brilliance and skill as an investigator and his dedication to his work and to his collaborators and students.

My own relations with him were as a friend and mostly in the summer, though even then we had many and long talks about the Harvard Medical School, its strengths and its weaknesses. But mostly, we swam and picnicked and played deck tennis or "intellectual" parlor games in the evenings. Once at a birthday party we were both "it" and we were each directed, unbeknownst to the other, to climb through a very small high window, but in opposite directions. We met head-on. There was great merriment below and George nearly fell off his ladder with laughter. And on another occasion he emerged from a wonderful salt-water pool on West Island with his head and shoulders and chest completely draped in kelp, lacking only a trident to be Father Neptune himself.

But our times together were not always jolly. We listened with tense horror to the radio at the news of the invasion of Poland. And on the day of Hiroshima he came down to our house, white with anguish and agitation, saying: "They've exploded an atomic bomb. This is the end."

I was with him at a Macy Foundation luncheon in New York when he had his first heart attack. He was prostrated and pulseless, but as soon as he had revived a little he tried to laugh it off and say it was all "neurotic."

After that he had much illness and suffering, but he continued to work and was more than ever devoted to his family and to his friends. He was fortunate in his wife—a wise, gallant, beautiful Demeter, always at his side in spite of her own busy professional life and their four children in whom George had increasing joy. He was as honest as any man I have ever known. If Diogenes had run into George Wislocki on a dark night, I think that he would have doused his lamp and gone back to his tub with a contented heart.

C. A. L. B.